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## ABSTRACT

By means of a survey of secondary school principals, whose schools are members of the East Texas School Study Council, a regional cooperative of over 80 schools in the North East Texas area, this study sought to determine the desired and existing roles of the principals in dealing with the adolescent suicide problem. The study also identified the areas of training the secondary school principals deemed important in dealing with depressed students and other potential suicide victims. In addition, the study examined whether there were any differences in responses from secondary school principals on the basis of the variables of incidence of suicide or attempted suicide or level of administrators. The data are presented in three sections: demographic data, data organized to answer research questions, and statistical analysis related to different variables. A review of literature related to suicide with a concentrated focus on youth suicide is included. (SI)

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# Adolescent Suicide and the Role of the School as Seen by Secondary School Principals

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## Chapter 1

### INTRODUCTION

Suicide is becoming one of the most talked and written about problems affecting adolescents of this country. With alarming rapidity, depressed teenagers are turning to self destruction as a high-priority option in dealing with their problems. In order to reduce the incidence of suicide, school administrators must have an understanding of this phenomenon which affects teenagers, their parents, and society as a whole due to the victim's loss of productivity.

The term "suicide" is applied to "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result" (Durkheim, 1951:44). Although our society considers suicide as a major problem, we have very few intervention skills or deterrent procedures for the act (Rabkin, 1978:28).

Suicide is a major cause of adolescent deaths. Additionally, suicide attempts and risk-taking behaviors such as fast driving, excessive drinking, and drug abuse are extremely high for adolescents. According to Maris (1985:99), the rate of suicide attempts and other precarious behaviors may be at least ten times higher for adolescents than any other group. The statistics on nonfatal suicide attempts yearly may reach as high as 250,000 to 500,000.

One reason that suicides and suicide attempts by adolescents have increased is because of changing expectations of adolescents. Early in our civilization the stage of adolescence was very short due to the passage into adulthood at a young age. Children entered into the ritual of marriage and the work force by early teenage years. Recently, the adolescent stage has been drawn out and expanded into a nonproductive time as perceived by some adolescents. Some teenagers see this nonproductive time as a "terminal illness." Adolescents turn to many outlets during this time of nonproductivity including drugs, sexual promiscuity, and periods of depression which lead some to thoughts of suicide (Maris, 1985: 99-101).

Rosenkrantz (1978:209) pointed out that adolescents are more likely to "over-react" to stressful situations. Teenagers make more attempts at suicide than do adults, perhaps as high as a ratio of 120 to 1. The more conservative estimates run about 20 to 1. Rosenkrantz states that college students attempt suicide more often than do young adults who do not go to college.

More than 90 percent of the children who committed suicide never received any psychiatric or mental health care. Programs should be established to educate parents, teachers, family practitioners, pediatricians, and clergymen to recognize the early signs of suicidal behavior (Hippchen, 1980:2).

Because suicide has increased over 300 percent in the last twenty years, school administrators are beginning to become concerned about their role in dealing with the problem. People in contact with youth are in the best position to detect suicidal signs. These include parents, friends, youth ministers, teachers, and administrators. Because teachers and administrators are not as closely related to the adolescents, they are usually more objective about the situation. They need to be extremely aware of the changing behaviors of the students. When a teacher or any school employee becomes aware of a student exhibiting indications of suicide, the most positive action is to listen carefully to what the student has to say (Powers, 1979:562). Any threat should be taken seriously and a trust relationship should be developed between the student and the school employee. This puts a responsibility on the teacher or administrator to determine if the situation warrants informing parents (Tugend, 1984:1).

### **Statement of the Problem**

The problem addressed by this study was to determine the desired and existing roles of the secondary school principal in dealing with the adolescent suicide problem. The study also focused on the area of training secondary school principals deemed to be beneficial in dealing with adolescent suicide. In addition, the study examined if there were any differences in responses from secondary school principals on the basis of the variables of incidence of suicide or attempted suicide, level of school, and school size.

### **Purpose of the Study**

The major purpose of this study was to determine the importance of actions which could be and are being taken by secondary school principals in a school to help reduce the incidence of adolescent suicide and to develop a possible model program for schools. The study also identified the areas of training that secondary school principals deemed important in dealing with depressed students and other potential suicide victims. In addition, the study determined if there were any differences in responses from principals according to the variables of incidence of suicide or attempted suicide, level of school and school size.

### **Research Questions**

The following questions were formulated as guides for the study. These questions were addressed to secondary principals in the East Texas School Study Council (ETSSC).

1. Is there a district board policy provision which deals with adolescent suicide?
2. What components of a suicide prevention program are most desirable and to what extent are they presently being used?
3. What methods are most desirable and are presently being used in the school to identify high risk students?
4. What importance is placed on informing certain school official(s) in secondary schools after high risk students have been identified?
5. What follow-up actions should be taken by the principal or other designated person after receiving a report of a potentially suicidal student?
6. What linkages with community resources that can help in dealing with adolescent suicide are accessible to secondary schools?
7. What importance is placed on certain actions which could be taken in secondary schools after a student suicide occurs?
8. What topics need to be addressed in a suicide training program that would be appropriate for secondary principals?

The above eight areas were examined for significance on the basis of the following variables: incidence of suicide or attempted suicide, level of school, and school size.

### **Significance of the Study**

Whereas much research has been done on adolescent suicide in general, little has been done on the school's role and responsibility in dealing with this problem. Because of the "epidemic" of teen suicides, educators need to develop guidelines and programs to deal with the crisis at hand. Principals, teachers, and counselors need to be trained to look for signs of suicide and to know how to talk with a depressed youngster. Individuals who counsel suicidal youth or survivors of suicide "need to come to terms with their own feelings about death and suicide, lest they hinder their work" (Stone, 1972:98).

### **Delimitations of the Study**

The following delimitations were established for this study:

1. The study was limited to secondary school administrators whose schools are members of the East Texas School Study Council (ETSSC), a regional cooperative of over eighty schools in the North East Texas area.
2. Only administrators of middle or high schools participated.

### **Definition of Terms**

**Suicide:** "Suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." (Durkheim, 1951:44).

**Crisis:** A crisis is a state of feeling, an internal event associated with anxiety and confusion, to the degree that formerly successful coping methods break down and ineffective decisions and behaviors take their place (Suicide and Crisis Center, Volunteer Manual). A crisis is a time of great trouble for a student, the outcome of which decides whether possible bad consequences will follow.

**High Risk Students:** High risk students are those who meet certain identified criteria that are considered to be warnings of possible suicidal behavior.

**Secondary Principals:** Secondary principals are those ETSSC middle/junior high or high school principals whose schools contain any combination of grade seven through twelve.

**Middle/Junior High Principals:** Middle/Junior High Principals are those principals whose schools contain any combination of grades five through nine which included grade seven.

**High School Principals:** High school principals are those principals whose schools contain any combination of grades nine through twelve.

**East Texas School Study Council (ETSSC):** The ETSSC is an organization based at East Texas State University that is composed of over eighty school districts in the East Texas area.

**Size of the school district:** For the purpose of this study, the schools were broken down into the athletic classifications of 1A to 5A. This information was obtained from the office of the University Interscholastic League in Austin, Texas. Schools are divided into five classification sizes according to the following high school enrollment figures: 1A schools contain 134 students and below, 2A schools contain 135 to 274 students, 3A schools contain 275 to 649 students, 4A schools contain 650 to 1304 students, and 5A schools contain 1305 students and above. A high school is defined by the University Interscholastic League as a school that is a unit of a school district and that offers instruction in the ninth, tenth, eleventh, or twelfth grade or any combination thereof, whether all of the grades are offered instruction in the same building.

### **Basic Assumptions**

This investigation will be based on the following assumptions:

1. The questionnaire was a validated instrument and thus provided appropriate data to answer the research questions.
2. All respondents to the questionnaire participated to the best of their ability.

## Chapter 2

### REVIEW OF THE LITERATURE

This chapter reviews the literature related to suicide with a concentrated focus on youth suicide. An analysis of publications pertaining to suicide is made to further understand the various aspects of self-destruction, in general, and teen suicide, in particular, in order to help the school administrator intelligently respond to the problem.

This chapter is divided into six areas. The areas deal with historical background, theories of suicide, incidence of suicide, causes of suicide and characteristics of suicidal youth, disclosing signs, and suicide and the school.

#### Historical

Suicide has been an occurrence since the beginning of humankind. Although it was unheard of in some cultures and tribes, suicide was a common happening in others (Dublin, 1963:83-84). During the ancient Roman era, the high frequency of suicide and the honor given to the suicide victims gave rise to the idea that suicide was merely a matter of social custom. There were some objections to suicide by certain leaders in Rome, as there had been in Greece. Plato and Pythagoras objected to suicide on the following grounds: (1) suicide was a rebelling act against one's maker—God; (2) suicide was an unnatural act against self, because man is supposed to be his own best friend; (3) suicide is a selfish act against the state; (4) suicide is a cowardly act because stressful situations will make one more noble (Dublin, 1963:111). During the time of Thomas Aquinas (Westermarck:1908, 252-54), suicide was labeled both a sin and a crime.

Aquinas considered suicide a sin for three reasons: First, everything natural loves itself and preserves itself in being; suicide is against natural inclination and contrary to the charity which a man ought to bear towards himself, and consequently, a mortal sin. Secondly, by killing himself a person does an injury to the community of which he is a part. Thirdly, life is a gift divinely bestowed on man, and subject to His power who 'killeth and maketh alive'; and therefore he who takes his own life sins against God, as he who kills another man's slave sins against the master to whom the slave belongs, and as he sins who usurps the office of judge on a point not referred to him; for to God alone belongs the judgement of life and death.

During the Romantic Period new focus and attention was given to the topic of suicide. Many educated persons of this era labeled suicide as a fundamental social problem (Douglas, 1968:376).

Before 1823 in England, suicide victims were carried to a crossroad and stakes were driven through their heart, and their possessions were confiscated by the state. In many instances, the bodies of suicide victims were dragged through the streets and left for birds to eat. Superstitions grew from these practices to the point that it was once thought that a pregnant woman who stood on the grave of a suicide victim would have a child that would also take its life by self-destructive means (Grollman, 1971:18).

Historically, suicide has been considered illegal in many countries. In England, during the nineteenth century and prior to 1916, the punishment for trying to commit suicide was imprisonment. The effect of these laws did not curtail suicides. The guilt these laws caused only added to the suicidal feelings this person had. The suicidally inclined person went into further seclusion, and this was the one thing that should not

have been done (*Federal Role In Addressing the Tragedy of Youth Suicide*, 1985:70). The English courts discovered that the penalty was not being upheld, so they decided to place the victim in the custody of relatives and family. The repeal of this law by the English Parliament in 1961 ended a one thousand year practice of considering suicide a criminal act (Grollman, 1971:18). Currently only India has laws which forbid suicide (Grollman, 1971:19). In the United States, it is no longer a crime to commit suicide, and only in Oklahoma and Texas is it a crime to attempt suicide (*Federal Role In Addressing the Tragedy of Youth Suicide*, 1985:70).

It was not until 1910 that several psychoanalysts met for the first time in Vienna to discuss their ideas about suicide. This forum focused on the role of education and the school in dealing with suicide. Freud (1967:61) stated at the 1910 conference:

... a secondary school should achieve more than not driving its pupils to suicide. It should give them a desire to live and should offer them support and backing at a time of life at which the conditions of their development compel them to relax their ties with their parental home and their family. It seems to me indisputable that schools fail in this, and in many respects fall short of their duty of providing a substitute for the family and of arousing interest in life in the world outside . . . . The school must never forget that it has to deal with immature individuals who cannot be denied a right to linger at certain stages of development and even at certain disagreeable ones. The school must not take on itself the inexorable character of life: it must not seek to be more than a game of life.

### Theories

Emile Durkheim is considered the first specialist in suicide. In his book, *Suicide: A Study in Sociology*, Durkheim made many outstanding contributions to the field of suicidology.

Durkheim wrote that suicide was either a disease in itself or was considered to be just a facet belonging to several kinds of mental diseases not found in sane persons (Durkheim, 1951:58). Durkheim purported: "If suicide can be shown to be a mental disease with its own characteristics and distinct evolution, the question is settled; every suicide is a madman." (Durkheim, 1951:59)

Durkheim divides suicide into three categories: egoistic suicide, altruistic suicide, and anomic suicide. Durkheim defined egoistic suicide as the individual's need to belong to something which transcends him/her and something that will not perish when life is over.

Altruistic suicide is quite opposite from egoistic suicide. When society binds its members in a manner that causes them to feel a great need to sacrifice themselves for the good of that society, then such sacrifice is praised highly by the remaining members of their group.

The anomic suicide rather than being caused by society, is brought about by the individual's perception of how he/she is viewed by that society (Durkheim, 1951:258). The anomic suicide is carried out by the individual who has set unobtainable or unrealistic goals. The individual has an enormous amount of guilt about a failure, and thus cannot endure the guilt for long periods of time (Durkheim, 1951:248).

Adler's theory of "Individual Psychology" deals with the idea that man is an object of inferiority. When a person is unable to find solutions to personal problems, that person creates a self-pity atmosphere whereby committing suicide will let those around feel this inferiority. Suicide is committed to invoke sympathy from the ones around (Adler, 1970:48, 63, 169).

Freud, founder of psychoanalysis, offered an early explanation for suicide. His

theory of the "death wish", introduced in 1920, stated that man's wish to die was equally as strong as his wish to live. His two drives were labeled eros (will to live) and thanatos (the will to die) (Freud, 1957:38).

Stekel's pronouncement that no one kills himself who has not wished for the death of another led to the theory that suicide is focused on hostility. This view is seen as symbolic murder (Stekel, 1967:102). Stekel also classifies suicide as a compulsive mental disorder. The struggling of both the death and life instincts come into play. The life instinct usually overcomes the death instinct, but this is not always the case (Stekel, 1967:23).

According to Shneidman, there are three types of suicides. First is the egotic suicide, in which the person is taking vengeance on the self. The feelings against self are so strong that there is little or no regard for the survivors, although the survivors may in fact be very supportive of the victim (Shneidman, 1969:13). This type of suicide is considered by professionals as delusional. As illustrated by the suicide notes, most of these victims had psychological problems. The notes were often written to self, and many of them contained symbolism, peculiar inner personal struggles, and unresolved philosophical issues (Shneidman, 1969:14).

Shneidman's second, and most prevalent, type of suicide victim is termed dyadic. Dyadic theory relates to the significant others in one's life. The victim may feel, "if she only knew how I felt," or "she will be sorry when I am dead" (Shneidman, 1969:14).

Shneidman's third type of suicide victim commits ageneratic suicide. This individual no longer feels a part of the procession of generations and thus repeals membership to the human race (Shneidman, 1969:15). With ageneratic suicides the notes may be addressed to "To whom it may concern" (Shneidman, 1969:17).

In relation to young people, Shneidman (1969:7) cites George Wald's theory of suicide which suggests that society now has a generation of young people who are unsure if life is even worth living, due to threats of war and nuclear annihilation. Wald also postulated that there will be another generation after them who will share this same attitude (Shneidman, 1969:7).

### Incidence of Suicide

Little validity should be given to the statistics related to suicides in this nation because many suicides are not reported as such (Grollman, 1971:7-8; Giovacchini, 1981:6; *Centers for Disease Control: Suicide Surveillance, 1970-1980*, 1985:5). The true American suicide rate may be twice the reported one (Grollman, 1971:8; Klagsbrun, 1976:16). Douglas (1968:380) states that the more a society has to lose from one of its members committing suicide, the more likely that the suicide will be labeled as another type of death. However, statistics show that there are about 50,000 suicides in the United States yearly with about eight attempts for each suicide completed. In 1980, statistics show that of the total number of people who committed suicide, seventy percent were white males, twenty-two percent were white females, six percent were Black and other males, and two percent were Black and other females (*Centers for Disease Control: Suicide Surveillance, 1970-1980*, 1985:3). There are approximately 750,000 persons intimately affected by suicide yearly (Shneidman, 1967:22).

The sharply increased rate of youth suicide during the sixties and seventies and the tremendous effect this had on the survivors gave rise to the experts' report of an "epidemic" in youth suicide. This epidemic can be stopped only if society quits ignoring the problem and openly seeks answers (Klagsbrun, 1976:4). Authorities estimated that about 400,000 teenagers attempt suicide within any given year (Crumley, 1979:A1). Between 1970 and 1980 the suicide rate for boys increased 50 percent while the suicide rate for girls had only a slight increase (*Center for Disease Control: Suicide*

*Surveillance, 1970-1980, 1985:3*). For every youth who commits suicide, there are an estimated 60 to 100 who attempt it. In addition to all of those who attempt suicide, there is an even larger number who contemplate it (Rabkin, 1978:173). The American Psychiatric Association reported that suicide rates for adolescents had reached a plateau in the 1980's (*Federal Role In Addressing the Tragedy of Youth Suicide, 1985:9*).

Suicide is nonexistent in ages under five, almost nonexistent in ages five to nine, and very rare in the ages ten to fourteen (Peck, 1979:4). For example, in a thirteen year period ending in 1978, there were only about 2000 cases of suicide reported for children under the age of 14 (*Federal Role In Addressing the Tragedy of Youth Suicide, 1985:2*). However in late adolescence and early adulthood, there is a frequency about eight to ten times greater than the previous groups (Peck, 1979:4).

Dorcas R. Hardy, in a statement to a U.S. Senate hearing on youth suicide stated, "Only between the sexes do we see significant differences in suicidal acts. Young women account for 90 percent of suicide attempts, while boys account for 70 percent of the 'successful' suicides" (*Federal Role in Addressing the Tragedy of Youth Suicide, 1985:10*). For boys, the most widely used methods are guns and weapons. The next most used method is hanging and the third is pills or poisons. For girls, the number one method is pills, and running a close second are guns and explosives. Hanging is the third most used method for girls (Klagsbrun, 1976:26; Hendin, 1982:143).

Youths who fail in their suicide attempt generally do so because they use methods such as pills or slashing their wrists, which usually leave ample time for rescue (Klagsbrun, 1976:26; Davis, 1983:17). A number of suicides are found with the telephone in hand, meaning that they did not actually want to die but were not found in time to be saved (Mahar, 1983:12; Pollack, 1971:32). About 10 percent of those who attempt suicide later go on to succeed at committing suicide within a ten year period of the initial attempt (Dorpat and Ripley, 1967:74).

Suicide is second only to accidents as the leading cause of death in the adolescent years. Many of the accidents may also be intentional suicides (McCoy, 1982:2; Mishara, 1975:32). About a third of college students' deaths are attributed to suicide (Peck, 1979:5).

Researchers also reveal other relevant information about self-destruction. More suicides occur between 3:00 p.m. and 6:00 p.m., probably because most families are mobile during this time and chances of being rescued are high (Klagsbrun, 1976:15). Statistics also show that suicide strikes both the rich and poor alike, although much of the public acknowledgement by the press goes to the rich and more affluent of society (Klagsbrun, 1976:14; Mueller, 1984:4; Giovacchini, 1981:6; *Federal Role In Addressing the Tragedy of Youth Suicide, 1985:10*). Furthermore, Dr. Alfred L. Moseley of Harvard Medical School has concluded that suicides make up a significant but unknown amount of the 48,000 annual auto deaths in the United States. This type of suicide is referred to as "autocide." (Grollman, 1971:11).

Other important findings are that 40 percent of teenagers who attempt suicide have lost parents to either death or divorce and the unemployment rate for parents of adolescents who attempt suicide is extremely high (Austin and Little, 1982:a23). In families where suicides occur, there seems to be a high correlation between initial suicides and suicides that follow in that the same type of method is used and even in the same time of the year. The victims of suicide are also about the same age as the previous family member when that family member committed suicide (Durkheim, 1951:79).

Almost everyone has thought about the idea of personal suicide sometime during life (*Teenage Suicide, 1984:55*). According to Meerloo (1962:65) approximately 80 percent of the population has thought of suicide. Dublin (1963:3) has said it would not be

too rash to estimate that about 2,000,000 people are now living in the United States that have a history of at least one unsuccessful suicide attempt.

Statistics show that married persons have a lower degree of suicide than single adults (Dublin, 1963:26). However, married persons under the age of twenty-four have a higher rate of suicide, possibly because many young people enter into marriage to escape home-life situations (Grollman, 1971:49).

As far as the time of the year when most people commit suicide, spring seems to be the most popular time when one's desolate feelings are confused by the refreshing feeling of nature (Grollman, 1971:64; Mahar, 1983:11; Dublin, 1963:56; *Centers for Disease Control: Suicide Surveillance, 1970-1980*, 1985:30). While most people believe that student suicides occur during examination time, Seiden (1966:390) found that the peak danger time is actually during the first six weeks of the semester.

### Causes of Suicide and Characteristics of Suicidal Youth

Adolescence is frequently a very stressful period for the teenager and also the parent (Giovacchini, 1981:15-16). Behavior problems are often expected and sometimes overlooked during this phase of life. According to Mahar (1983:11-12):

It's easy to surmise why teenagers are particularly vulnerable to suicide. Adolescence has its own built-in turbulence. The passage from child to adult brings more changes than at any other time of life. Teenagers are often confused. Their judgement, emotions, and bodies may not mature at the same rate. They have enormous pressures—to gain peer acceptance, to make grades, to get into college or choose a career, to achieve, to live up to a parent's expectations. On top of all this, they do not have one advantage that all adults enjoy. They do not yet understand that, indeed, all things will pass.

Suicide is one way adolescents deal with stressful situations. Teicher and Jacobs (1966:1254) have identified five other ways in which adolescents deal with their problems: "... physical aggression, rebellion, withdrawal, physical separation from the problem or by internalizing the problem where it manifests itself in the form of psychosomatic illness."

Many adolescents who attempt suicide have no real intention of dying, but suicide is a "cry for help" and a call for attention. Usually this cry for help comes after many other calls that are less dramatic and are not as loud (Klagsbrun 1976:25; Giovacchini, 1981:10; *Teenage Suicide*, 1984:31).

Many of the specialists disagree as to the cause of youth suicide, but most agree that lack of a stable home environment is a major factor in adolescent self-destruction (*Teenage Suicide*, 1984:31; "Teenage Suicide—Florida's Tragedy," 1984:10; Hendin, 1982:51-52). More than 50 percent of the empirical work on suicide involves some aspect of the family life in its investigation (Heilig, 1983:3). Many homes include only one parent and if there are two, there is frequent quarreling among its members. This environment is not structured and does not offer children the love and support they need (Rabkin, 1978:50). Adolescents need the support of a stable home environment to work out all the problems they encounter during this period (Giovacchini, 1981:15). Frustration possibly leading to depression may arise if the adolescent feels he is not a part of either the world of the child or the adult world. The child's lack of responsibility is left behind. The adult world is awaiting, but admission has not yet been granted (Rabkin, 1978:73).

Another factor is that parents really do not understand the feelings of their children. Parents may think that because they were able to overcome their problems, surely their children will be able to do so. Some parents talk to their children on a level that

is too complicated for them to really understand. Even though the child may have a vocabulary which is extraordinary for a young person, he may not truly be able to synthesize the issues about which he can talk (Klein, 1981:10).

According to the American Orthopsychiatric Association, some causes of youth suicide stem from pressures that are put on children at a young age. Some youth feel they are unable to meet the demands of perfection put on them by their parents (Grollman, 1971:52). Freud also suggested that schools were responsible for introducing youth too rapidly to the problems that adults encounter (Freud, 1957:232).

Depression, which is linked to most youth suicides, occurs in various forms. Psychotic depression occurs from mental disorders such as brain tumors, schizophrenia, and in some cases extreme exhaustion. This disorder can bring about sleep disorders, feelings of hopelessness, hallucinations, and a sense of withdrawal from the outside world (McCoy, 1982:35, "Children In Trouble," 1985:1). Manic-depressive is a type of depression that is considered to be bipolar, with frequent, hard-to-predict ups and downs. This type is different from unipolar depression in which the sufferer has long periods of depression. Reactive depression occurs from a reaction to something traumatic in a person's life, such as the loss or breakup of a parent or girlfriend or even the loss of a beloved pet. This type of depression usually disappears when the person has time to work through this state and learns to cope with this loss (McCoy, 1982:31). While most teenagers' depression is a reactive type, some suffer from endogenous depression which is caused by a type of chemical change in the brain. Researchers are currently studying the biochemistry, genetics and toxins associated with this type of depression (McCoy, 1982:31). Low amounts of serotonin have also been found in suicidal victims (Asberg, 1981:368). Dr. David E. Comings of the City of Hope National Medical Center in Duarte, California, discovered especially high amounts of a certain protein he later called Pcl Durate in suicidal victims. He thinks that this protein, which is found in large amounts in suicide victims, makes them particularly susceptible to depression and even suicide. He is being very careful not to say this is a cause and effect relationship but does say that this genetic factor linked with environmental factors may result in severe depression (McCoy, 1982:33).

Depression can stem from an illness, injury, situation, or condition that sets a teenager apart from his peers either temporarily or permanently. This is a particular problem with teenagers because during this period teenagers are particularly concerned with body image. Height, breast size, testicle size and even one pimple may become major worries (McCoy, 1982:18). There also appears to be an association between youth suicide and the menstrual cycle. Statistics show there are a large number of suicide attempts during premenstrual and menstrual periods (Finch and Poznanski, 1971:35). Sexual experiences too early in life are also thought to be a contributing factor in adolescent suicide ("Teenage Suicide—Florida's Tragedy," 1984:10). About 5 percent of all female suicide attempts deal with the issue of pregnancy. Also about 7 percent of all women who commit suicide are pregnant (Finch and Poznanski, 1971:36).

Farberow (1961:65-75) gave several reasons for one committing suicide. A person may become dependent on another, and then when that relationship is threatened, the person becomes suicidal. A person can also use suicide as a way of hurting others and a way of manipulating others in a kind of psychological blackmail. The previous example of suicide can also be a self-inflicted punishment to a significant other. Another reason for suicide is to gain control of some aspect of one's life, which seems to be in a state of chaos. Finally, a suicidal person can use suicide as a way to adapt to his particular situation or environment. For instance, the captain may feel it is his duty to go down with the ship. Suicides come from both neurotic and psychotic disturbances. Neurotic causes can usually be treated if the problem is discovered in time.

Psychotic illness is of more concern because people with this condition lose contact with reality (Klagsbrun, 1976:52).

Divorce can also cause depression, for sometimes divorce is more critical than death because the permanence of death is not there. In divorce, the parents drop into and out of the child's life, giving the child a sense of hope followed by despair and then depression (McCoy, 1982:13).

Learning disabilities are also a contributing factor to depression and youth suicide. The accompanying depression is often caused by a student's low self-esteem and also the teasing received from peers (McCoy, 1982:21).

Adolescent suicide has become a major concern to society as evidenced by the National Institute Of Mental Health's report on the causes of youth suicide. The causes, as reported to the Committee On the Judiciary United States Senate Ninety-Ninth Congress (*Federal Role In Addressing the Tragedy of Youth Suicide*, 1985:24-26) are as follows:

1. Risk Factor Research—While not all young people who attempt or commit suicide have an underlying psychiatric disorder, depression and chemical dependence are important risk factors for suicide. Young people who have disorders involving their conduct (such as truancy, stealing, confrontations with the law, and running away from home) and are more impulsive and aggressive are at an increased risk for suicide. One of our most important prevention strategies is the early detection and treatment of mental disorders and chemical dependence.
2. Psychosocial Risk Factors—These include loss of a loved person, multiple moves and stresses as the young person has developed, chronic illness, being the victim of child abuse, being a runaway, having an unwanted pregnancy, and having experienced a recent humiliation in front of family or friends. Personality characteristics of adolescents who completed suicide have included antisocial behavior and/or a history of aggressive and impulsive behavior, isolated depressed youngsters and perfectionistic young people who experience injuries to their self-esteem.
3. Biological Risk Factors—Recent biochemical investigations of suicidal behavior have shown reduced levels of serotonin, a key chemical messenger in the brain, associated with increased aggression in violent suicide attempts and completions which may increase the risk of completed suicides twenty-fold. Research on biological factors may hold promise for increased prediction of suicide, new psychopharmacologic treatment interventions and ultimately prevention of suicide.
4. Genetic and Familial Risk Factors—A family history of suicide increases the risk of suicide eight-fold. Explanations for this include the psychological phenomenon of identification with a family member who has committed suicide, genetic factors for suicide, and the genetic transmission of psychiatric disorders.
5. Suicide Clusters—Another characteristics of the current suicide problem merits serious concern. "Suicide clusters" are occurring at an increasing rate among adolescents. The term, "suicide cluster," refers to the phenomenon of one suicide appearing to trigger several other suicides in a group, such as a school or community. Very little is known about this apparent contagion effect of suicide among adolescents. Suicide clusters have recently occurred in Plano, Texas, in Westchester County, New York, in Minnesota, and in Clear Lake and

Houston, Texas. NIMH funded studies are underway at Columbia University to investigate the mechanism of suicide clusters. Analysis of these data should be completed by December, 1985. Increased understanding of these factors should lead to prevention strategies.

Identity problems are also listed as reasons some youth have suicidal thoughts. In some cases, boys are forced by their rigid fathers to grow up and "be a man." This may have a reverse effect because many times adolescent boys are struggling with their masculinity and their sexual identity. The demand to "be a man" oftentimes cause boys to lose their identity and to feel inadequate (Peck, 1968:114).

Other factors such as communities in transition, in which a youth loses friends because families move into and out of the area so readily, may also be seen as a stress-producing factor. Some youngsters see death as a relief from this stressful situation (Austin and Little, 1982:1).

There also seems to be a connection between child abuse and suicide. Many youths' self esteem is threatened and broken down by abuse. There is a positive correlation between sexual abuse and suicide ("Teen Suicide: Alarming Trend on the Rise," 1985:7; Federal Role In Addressing the Tragedy of Youth Suicide, 1985:11). Many of the suicidal signs and symptoms are found in children who are runaways and homeless as compared to youth in general.

During the Sixties youth seemed to have a way to vent their anger and frustration. Now it appears that youth are much more reserved and much more inhibited in their actions. Today many youngsters do not want to follow in the footsteps of their parents but do not see they have an alternative. This has resulted in a loss of optimism and a lack of direction for the teenagers (Klein, 1981:11).

The one causative factor which appears to link all youth suicides is that the victims are so depressed that they feel living would have no purpose, and thus, their death cannot be avoided (Ognitz, 1978:20). As stated by Fujimura, Weis, and Cochran (1985: 613):

A characteristic profile of a suicide victim is hard to determine mainly because it is difficult to accurately assess the suicide fare. Both the statistics and characteristic profile of a suicide victim are relative to the time and place that they are being assessed. One common characteristic that all suicide victims may share, however, is a feeling of depression that usually is a reaction to a perceived loss. There may also be feelings of helplessness, despair, and worthlessness involved.

### Disclosing Signs

The warning signs of an individual contemplating suicide are not always difficult to find once the decision-making process to kill oneself has begun. These signs may be both verbal and behavioral (Valente, 1985:47). The majority of people who are thinking of suicide actually give signs prior to their action (Seiden, 1966:399; Farberow, 1968:390). Many times people do not react constructively to these signs because they do not take the suicidal person seriously. Sometimes the cry "suicide" comes so often that the listener regards the cry as another manipulative maneuver (Fujimura, Weis, and Cochran: 614).

The typical suicidal person may manifest the following signs: ambivalence, feelings of hopelessness, lack of communication skills, mood swings, unusual sleeping habits, and unusual displays of hostility. A person showing these signs is not necessarily suicidal, but such symptoms are good indicators to evaluate the situation and determine if the individual is actually suicidal (Stone, 1972:12-13).

Many adolescents show signs of hyperactivity. They get overly involved in activi-

ties, show signs of restlessness, misbehave in class and cannot seem to relax. These activities are often a mask for depression which is usually just under the surface (McCoy, 1982:45).

Depression is an indication of trouble. When a suicidal adolescent is around others who are happy, the results can cause the adolescent to become even more depressed (Gordon, 1985:14).

Constant accidents such as automobile accidents, falls from bicycles, and falls from a tree are good signs that one should observe a child closely. Fast driving, risky actions, dangerous sports, and running away from home are also considered causes for concern. However, in no way should conclusions be drawn that a child like this is definitely suicidal. It could very possibly be that the child is more active than most and is exposed to these types of accidents more frequently (McCoy, 1982:47).

Another sign that is associated with the suicidal youth is that of isolation. If a child is suddenly withdrawn from his peers and keeps to himself either by a decline in family activities or isolation in his room, he should be monitored more closely (O'Roark, 1982:3). Because such teenagers spend a lot of time alone, they often have no one with whom to discuss their feelings (Hutto, 1985:6).

Becoming sexually promiscuous is another clue for families and friends to observe the youth more closely. Promiscuous actions tend to put youngsters in a high risk suicidal category (McCoy, 1982:44; "Teenage Suicide—Florida's Tragedy," 1984:10).

Food, music, dependence on others, and previous family attempts all seem to play an important part in adolescent suicide. Lack of interest in food accompanied with rapid weight loss is a strong sign of depression. A rapid weight gain can be just as serious a clue (McCoy, 1982:43). Listening to sad music seems to be common among suicidal youth, especially listening to the same song over and over again (Ognitz, 1978:20). The suicidal individuals are usually very dependent and demanding. They usually see themselves as inferior or helpless and are continually depending on others for happiness (Stone, 1972:11). Garfinkle found that teenagers who kill themselves are six times more likely to have experienced a family suicide. The successive victims follow the same pattern because they see this as an answer to their desperate flight from their troubles (Austin and Little, 1982:21).

When dealing with causes, one must look at the social demands put on youth by peers. Chronic alcoholism and chronic drug abuse as a slow form of suicide are examples of these pressures. (Klagsbrun, 1976:21). Also youth with psychopathy, who may be clinically depressed, schizophrenic, or paranoid may be likely candidates for suicide ("Children in Trouble," 1985:1). Clinically and socially, the most significant factors related to suicide are violence, alcohol abuse and homosexuality (Hendin, 1982:20).

### Suicide and the School

School administrators must be involved in the preventive measures of youth suicide. While most investigators agree that there are very few "absolutes" when dealing with suicide, all agree that ignoring the situation will not make it disappear (Davis, 1983:iv). According to a poll of October, 1985, ("Finding: Suicide Prevention Belongs In Schools," 1985:55) a majority of respondents report that suicide prevention programs are appropriate for public schools. Schools all over the country are beginning suicide awareness programs ("Suicide Prevention in the Schools", 1984:1). In 1983, U. S. Senate Bill 947, The Youth Suicide Prevention School Program, became the first of a series of laws which affect the school and suicide prevention. This law only gave attention to the prevention of suicide through educational training. Florida Senate Bill 529 addresses the issue of adolescent suicide by mandating a comprehensive school suicide program. New Jersey also has a bill which addresses youth suicide.

Alabama introduced a bill into its legislature called the Alabama Youth Educational Guidance and Suicide Prevention Act. Many other states have pending legislation which deals with the suicide problem (*Federal Role In Addressing the Tragedy of Youth Suicide*, 1985:71).

Because of the increased mobility of students, sometimes schools are the only system of support for some youngsters. A role of the schools is to educate youth to be intelligent and productive citizens in society. To fulfill this role, schools must consider how to help students maintain mental health. According to Canter, the best way to make an impact on youth suicide is to increase the amount of educational material available to schools, parents, teachers, communities, and children (*Federal Role In Addressing the Tragedy of Youth Suicide*, 1985:73).

Educators need to develop programs to deal with the crisis at hand because of the "epidemic" of teen suicides. Principals, teachers, and counselors need to be trained to look for signs of suicide and to know how to talk with a depressed youngster. Fujimura, Weis and Cochran (1985:612) stated:

It is important for counselors to be skilled in the areas of suicide prevention and intervention in order to prevent clients from tragically ending their own lives prematurely. These individuals are often experiencing a crisis of short duration and can be saved if helped and supported through the crisis.

Teachers are in a unique position to help teenagers during troubled times because they are with them on a recurring, long-term basis. Teachers are able to detect changes in students on a one-to-one basis and also in the context of their peers. Probably the teacher can detect signs of depression before any other adult with whom the youth has personal contact (Hafen and Faux, 1972:232; Christman, McKenry and Tishler, 1980:131). But for the teacher, the role should not be one of a therapist, but one that assures the student that someone is aware that there is a problem. The teacher should then tell the student that in his best interest, someone with more expertise should be notified (Hafen and Faux, 1972:232). Barrett, (Glaser, 1982:19) stated that schools should not act as a mental health clinic for long term therapy for suicidal youth, but the crisis for the youngsters does not take place in the psychiatrist's office. The crisis many times happens in the school, so this should be the place where the intervention takes place. Schools are the place where the child is most likely to talk and discuss personal problems.

The Administration on Children, Youth and Family and ACTION are developing several brochures, especially for school personnel, that list the potential signs of suicidal students (*Federal Role In Addressing the Tragedy of Youth Suicide*, 1985:10). Some of the most common signs of depression are related to the schools. These include such signals as excessive truancy, a decline in grades, fights with peers and teachers, and a withdrawal from social functions. Acting out in class may be a warning sign for troubled students. School is to the child what work is to the parent. Thus, school is a focal point of rebellion because teachers and parents have high expectations for the child in this area (McCoy, 1982:48). According to a study by Rohn and others (1977:636-638), of the sixty-five young people studied who had attempted suicide, 75 percent had poor scholastic records, 35 percent were truants, 35 percent had chronic discipline problems, and 19 percent failed one or more grades.

School phobia can result from severe depression which affects a teenager to the point that one cannot function in the school's realm and cannot fulfill the expectations. This phobia can intensify the child's fear, and the school becomes an impossible task for the individual (McCoy, 1982:133). There seemed to be a high degree of student suicide attempts when students were not making good grades or were anticipating poor grades. The underlying problem was not the bad grades, but the internal pres-

sure to succeed. This pressure was often necessary to satisfy parental expectations. To the student, failure means the loss of love from the parent, and that is something the student can not handle (Peck, 1968:114).

Educators are in a unique position to play a significant role in helping students deal with the isolation tendencies which are a result of depression ("Educators Should Deal With The Whole Child," 1983:2). For example, teachers can have classroom discussions about depression to help the depressed student (Johnson, 1985:117; Christman, McKenry and Tishler, 1980:132). Albert and Beck's study (1975) of seventh and eighth grade students in a coeducational parochial school found that 33.3 percent of the students described their feelings as being moderate to severe depression and that 35 percent were experiencing an acknowledged, current, suicidal idea. Albert and Beck's study concluded that early adolescents who had not been identified as patients of any sort were experiencing high degrees of depression. They also concluded that the interpersonal relations between the children and school personnel had a direct relationship to the student's self-concept and subsequent emotional health.

The steady rate of increase in adolescent suicide and general depression indicates a need for school personnel to be trained to recognize and to understand depression/suicidal behavior in students. Teacher education programs should help prospective teachers deal with the psychological aspect of the child ("Educators Should Deal With The Whole Child," 1983:2). Teachers should be encouraged to utilize candid and meaningful open discussions about suicide with their students (Johnson, 1985:115). A major factor for teachers is to listen and learn from the attempter. It is important that a person should not pressure or lecture the attempter (Ruffini, 1984:1). A common mistake is to avoid talking about the attempt because it might bring morbid ideas to the suicidal person. If the person has the ideas, someone can help by bringing these ideas to the surface and encouraging the suicide survivor to talk and work through these feelings (Klagsbrun, 1976:15).

The best preventive measure is to develop an intimate relationship with attempters, because their underlying feeling is a lack of self-worth (Austin and Little, 1982:a21). Important skills in dealing with suicide attempters are to listen and react (Powers, 1979:562). Questions have to be direct and to the point instead of aimed at trying to smooth over the bad feelings (Kleiner, 1981:89). The listener should not try to solve the child's problem, but should listen and encourage the child to derive answers to their own problems ("Suicide Prevention Programs Assist Educators and Parents," 1985:15).

According to a study done by Gordon (1979:124-28), secondary school teachers in Dallas County possessed little knowledge about the problem of adolescent suicide and the potential for teacher intervention. From this study, recommendations were suggested to develop curricula for pre-service and graduate courses which would address the issue of adolescent suicide. It was also suggested that addressing adolescent suicide in in-service would also be a positive step in dealing with the suicide issue (Gordon, 1979:xv).

California, Florida, and New Jersey have passed laws requiring schools to offer suicide-prevention in the secondary schools. In New York there is also legislation to deal with this problem (Tugend, 1984:a12). In Louisiana, a unit on suicide must be incorporated into the health classes. The teacher has the obligation to find the material to use to teach the section, but at the teacher's request, community speakers may be invited for class discussions ("Suicide Prevention in the Schools," 1984:1).

The "Florida Youth Emotional Development and Suicide Prevention Act" requires that suicide prevention programs be a part of the life-management classes offered to ninth and tenth grade students (Hutto, 1984:10). The law also requires teachers to be trained in suicide prevention so they "can recognize signs of emotional distress in stu-

dents and [learn] techniques of crisis intervention, with emphasis on suicide prevention and positive emotional development" (Tugend, 1984:a12).

According to Charlotte Ross, executive director of The Suicide Prevention and Crisis Center of San Mateo County, California, and co-chairman of the National Committee on Youth Suicide, schools are afraid to act but are also afraid not to act. She says that schools fear they may cause a suicide by talking about it. School programs that are devoted primarily to suicide are relatively new; but in communities where there has been a rash of suicides, they are becoming common (Tugend, 1984:1).

Ross helped begin one of the first school-based programs which deals with youth suicide. She realized this need when her organization found that teachers do not know how to deal with adolescent depression. She reported cases in which an English teacher would grade an essay by a student on suicide and return the essay corrected for grammar. Consequently, she developed a program that would be widespread, short term, and inexpensive. Ross, as a part of this program, developed a pamphlet for teachers and also one for students on how to help themselves and their peers. The program did not start a rash of suicide as some had expected, but, in fact, the suicide rate dropped from eleven in 1975 to two or three a year (Tugend, 1984:1).

In Bergen County, New Jersey, school officials claim they have one of the largest school-based suicide prevention programs in the country which trains administrators, teachers, and parents in thirty seven secondary schools (Tugend, 1984:a12). In their program they talk about the current status, the school procedures, and the available resources related to suicide. Teachers in the school want this information because they are aware that they will encounter at least one severely depressed student in their career (Tugend, 1984:a12).

The Fairfax County, Virginia, school district began a suicide prevention program in 1981 in response to twenty adolescent suicides in one year. Myra Herbert, coordinator of school social-work services for the school system, said school officials decided to make a concentrated effort to educate students, teachers and parents alike (Tugend, 1984:a13; "Suicide Prevention Programs Assist Educators and Parents," 1985:15).

Very little research has been focused directly on the benefits of suicide awareness programs in schools. Because of this, Larry Silver, Deputy Director for Special Projects of the National Institute of Mental Health, suggested that the effects of secondary suicide prevention programs be studied. He suggested that determination of the materials, methods and treatment strategies used are needed (*Federal Role In Addressing the Tragedy of Youth Suicide*, 1985:27-28).

The most important preventive program would be one in which listening is the main function. When the school professional becomes aware of the warning signs exhibited by a student, the best action is listening (Powers, 1979; Valette, 1985:45). The threat should be taken seriously and then the responsibility lies with the professional to determine if the situation warrants informing the parents (Tugend, 1984:a13). In some cases "informed inaction" may be the best thing to do until the situation can be more fully assessed (Powers, 1979:562).

Pressure is greater in high schools of the suburbs where families of ambitious executives and professionals reside. The youths of these families often challenge the curricula and enroll in the advanced or college-level courses. The competition is on a greater level and the average or just above average students are highly affected if they cannot be the best. Some adolescents feel stupid, even though they are of average intelligence (Klein, 1981:10).

Teachers influence the success of their students, and sometimes the students' ability becomes more advanced than the teachers. This often results in the teacher's becoming less sympathetic to the students needs (McCoy, 1982:20).

Suicide rates are in direct correlation with achievement pressures. In the United States students feel pressure to achieve and in some cases would rather kill themselves than fail (McAnarney, 1979:771).

Iris Bolton of the Link Counseling Center in Atlanta feels coping skills should be taught in the school curriculum beginning in kindergarten. First, Bolton teaches that survival procedures should be incorporated into the classroom to develop the individual's self-esteem. Intrinsic values of who they are and not what they do should also be taught. Second, communication skills should be developed so that the students can express their true feelings. Thirdly, a degree of positive failure should be incorporated in a manner so that adolescents enjoy and grow from it, regardless of the outcome. Finally, students should be taught skills to handle grief. These skills should be taught by all teachers (O'Roark, 1982:120). Thomas Barrett, director of Cherry Creek Suicide Prevention program, said that because most crises occur at school, schools need to develop peer counseling programs and require courses in suicide prevention (O'Roark, 1982:120).

As teachers become familiar with prevention programs, they can offer more aid to troubled students. Suicidologists agree that school personnel should be aware of the following major signs of a student at risk (State Education Department, pp. 3-4).

**A student at risk of suicide often:**

1. has previously attempted suicide;
2. has made a suicidal gesture (cut off hair, self-inflicted cigarette burns, self-abusive behaviors);
3. is socially isolated (no friends or only one friend);
4. has a record of school failure or truancy (may have dropped out of school already);
5. comes from a broken home, has experienced a broken relationship at home, or has a family crisis at the time of the suicide;
6. is highly perfectionistic, self-critical, and has low self-esteem;
7. has spoken of suicide, either his or her own or others;
8. has a close friend or relative who was a (recent) suicide;
9. has experienced alcoholism or drug abuse in family or self;
10. is not living at home;
11. is a victim of domestic violence or child abuse at home;
12. is preoccupied with death or dying;
13. has had a significant loss or anniversary of a significant loss;
14. displays sudden disruptive or violent behavior in dealing with others;
15. has deep depression and feelings of worthlessness;
16. is more withdrawn, uncommunicative;

**In addition, the student may have:**

1. told others of definite plans to commit suicide;
2. made arrangements to give away possessions;
3. undergone marked changes in behavior ("class clown," dare-devil behaviors, suddenly hyperactive), at school or at home, involving eating, sleeping, studying, or grooming habits, or in using drugs or alcohol;
4. a background of hyperactivity or neurological impairment.

Should a teacher become aware of a possible suicide, the National Education Agency Brochure ("NEA Fights Teenage Suicide," 1985) suggests:

**Do's**

1. Listen to what the student is saying, and take his or her suicide threat seriously. (Many times a student may be looking for just that reassurance.)

2. Ask whether the student is really thinking about suicide.
3. Get help by contacting a trained professional. (In a large school this may be the school nurse or guidance counselor. In a small system, it will be the principal. That person, who ideally should be of the same racial or ethnic group as the student, should notify the parents.)
4. Call a physician or member of the clergy as required.
5. Stay with the student. Take the student to the school nurse, counselor, or principal yourself, and stay together for awhile.

#### **Don'ts**

1. Do not leave the student alone.
2. Do not underestimate or brush aside a suicide threat.
3. Do not let the student convince you that the crisis is over.
4. Do not take too much upon yourself. (Your responsibility to the student in a crisis is limited to listening, being supportive, and taking him or her to a trained professional.)

The teacher should be a neutral person with whom a youth can talk. Many times a young person becomes suicidal when there is no one left to manipulate. Sometimes the teacher is the neutral figure with whom the student can play the "Push-Pull" game ("Adolescent Suicide: What You Should Know," 1983:9). The period immediately after a depressing situation can be most critical because this is usually the time during which a person has made a choice about how to deal with the feelings they are having. One of these options may be that the person has decided on suicide (Klagsbrun, 1976:13). Once a person has attempted suicide, the barrier has been broken from thinking to acting. A person finds it easier to try a second or third time if the conditions precipitating the first attempt have not changed. Research shows that out of every five persons who complete suicide, four have made a previous attempt (Klagsbrun, 1976:12-13).

The opportunities for suicide prevention programs in schools abound. School personnel can introduce the topic of suicide in the curriculum in classes such as health, literature, social studies, psychology, sociology, home and family living, and in other areas such as parent-teacher organizations, in-service, and workshops. The school may even want to develop other support groups for students that deal with common problems relating to divorce, death, and other traumatic experiences that adolescents encounter. One way these goals can be obtained is to establish a counselor "drop in center" where students can go to talk when they need someone to listen (State Education Department, p. 4). School assemblies might be a good place for a mental health professional to discuss the adolescent suicidal issue, (Christman, McKenry, and Tishler, 1980: 132).

Another area of great concern for the school is postvention, after a suicide occurs. Local persons who have had experiences dealing with death and dying should be contacted (Powers, 1979:561). It is good to use on-hand school personnel. However, in some cases they too are so directly involved that they, also, need counseling. The community should be aware of the "domino effect" that results after a suicide such as "If my best friend did it, I can, too." (State Education Department, p. 4)

Once a suicide occurs in a school, the entire school and community will find it hard to continue with the activities of life ("Children In Trouble," 1985:1). There are several methods which should be considered when trying to deal with post suicide. The State Education Department of New York (State Education Department, pp. 5-6) suggests various procedures for post suicide activities. First, administrators should consult with the faculty and formulate a plan to deal with the suicide in individual classroom groupings. Faculty should understand the concept that no one is re-

sponsible for the death of someone else. Also, it is important to discuss the factors surrounding the death and stop the rumors before they start. Powers (1979:561) suggests that a respected mental health specialist from the community be invited in to discuss with faculty members different approaches to helping students discuss and explore their feelings regarding suicide.

Second, condolences should be expressed to the family. However, timing is important to avoid interrupting grief processes. Third, one school person should be designated to answer the questions of the community and the press. The spokesperson should include enough information in the release to explain the reasons of death so that others will not blame themselves. The staff should also be aware of the fact that usually the grieving parents will try to distort the characteristics and blame others, such as teachers and peers, and usually overstate the unrecognizability of prior signs. Fourth, adult study groups and small discussion groups should be started as soon as possible to help deal with the helplessness and frustration of those involved. In addition, students who need help in the grieving process should be given the opportunity to confer with counselors and have their feelings accepted, whether positive or negative. Finally, the event should not be allowed to interfere with normal activity any more than absolutely necessary (State Education Department, p. 6).

The feelings and reactions which students might experience after a suicide are many. As discussed by Farberow (1968:394), possible reactions are as follows:

1. strong feelings of loss, accompanied by sorrow and mourning;
2. strong feelings of anger for (a) being made to feel responsible, or (b) being rejected in that what was offered was refused;
3. guilt, shame, or embarrassment with feelings of responsibility for the death;
4. feelings of failure or inadequacy that what was needed could not be supplied;
5. feelings of relief that the nagging, insistent demands have ceased;
6. feelings of having been deserted, especially true for children;
7. ambivalence, with a mixture of all the above;
8. reaction of doubt and self-questioning whether enough was attempted;
9. denial that a suicide has occurred, with a possible conspiracy of silence among all concerned; and
10. arousal of one's own impulses toward suicide.

After a suicide, grieving persons usually go through four stages. The first stage is a stage of shock for all survivors. This sometimes comes as a complete shock to the survivors, but it may also come after warnings that have often either been overlooked or disregarded as an attempt to get attention. The shock usually lasts twelve to forty-eight hours and is sometimes extended if the grieving person is drinking or on medication. In the second and worst stage, the person goes through a "whirlwind" of emotions. This is the time of rage and anger about the suicidal person. It is also a time for guilt and confusion as to why the victim committed suicide. If this feeling lasts more than several weeks, professional help should be obtained. Sometimes ministers and family members can help during this period; but it has been noted that if this feeling persists, the person may contemplate suicide himself. The third stage, referred to as the "resolution" period, is one of the most important. This stage lasts from one to three months. This is the stage in which a person comes to grips with their own feelings about the victim's suicide and usually realizes that if someone is determined to commit suicide, there is not a lot anyone can do to prevent the death. The final period of grief is the reconstruction stage in which a person realizes that life can and must go on without the individual and the person continues with his own life (Johnson, 1981:10).

Of course, natural death leaves the survivors with a great deal of pain and grief, and sometimes these emotions are intensified to unbearable proportions. Because the suicidal person has had to deal with much mental pain prior to his death, the survivors not only must resolve their separation anxiety but also must work out feelings of guilt, shame, and self-blame (Grollman, 1971:3).

The Adolescent Suicide Project, conducted by the Suicide Prevention Center, Inc., Dayton, Ohio, is one source for providing education. This project also substantiates that teachers who communicate openly with students serve as better intervention people (Johnson, 1985:115).

In the spring of 1981 data were collected at the Dayton coroner's office as to the frequency of suicide and the related facts surrounding these suicides. Then a questionnaire was sent to the sixteen schools in Montgomery County seeking information about how many students had committed suicide, age of these children, sex, attempted suicides, and suicidal activities in their families. Of the sixteen schools, thirteen questionnaires were returned. The research showed school districts had drastically underestimated the suicidal activity (Johnson, 1985:115-116).

Next, the resistance to adolescent suicide was addressed, and a questionnaire was sent to teachers and students to attempt to resolve this resistance. Items included on the questionnaire were knowledge of warning signs, depressive suicidal behavior in youths, acceptance of these signals as a cry for help and finally, the knowledge of appropriate intervention skills and cause of action. One of the areas that students were tested on was if the students knew that a friend had become suicidal, would they confide in the teacher. The experimental students showed an increase in their willingness to confide in the teacher ( $p .03$ ). The experimental group of teachers and students went to the adolescent suicide presentation and after sharing the experiences of the program, the students felt closer to their teachers (Johnson, 1985:115-116).

After the program there was a post-test to find out if there was an increase in the number of thoughts of suicide. There was not a significant increase in either group. The post-test did show an increased knowledge of resources to obtain aid for suicidal youth ( $p .01$ ) and an increased knowledge about the myths concerning suicide ( $p .02$ ). Another result was development of the attitude that the suicidal person is not necessarily mentally ill ( $p .001$ ). The results of this study further indicated that teachers felt comfortable talking with students on an individual basis but were uncomfortable talking about the subject of suicide as a classroom topic (Johnson, 1985:116).

Many experts believe that peer counseling groups should be incorporated in the school because the likelihood that a student will go to a friend before going to an adult (Mahar, 1983:11). The friend should not act as a counselor, but as a liaison between the troubled friend and an adult (Teen Suicide: Alarming Trend on the Rise, 1985:8). The teenage friends should always be on the lookout for warning signs given to them by a troubled youth (Sheard, 1985).

According to Ray and Johnson (1983:135), an effective method which can be used by any counselor is the *ABC method*. Utilizing this method the counselor first *acquires* information about the problem and establishes a working relationship with the client. Then the counselor begins to *boil* down the situation. During this stage, the focus is developed and feelings are discussed and the stress involved is disclosed. The last level is the *coping* stage in which a counselor begins to explore alternatives and significant others to help in this time. A plan of action is established, and the client usually feels a sense of relief during this stage. This method of crisis counseling is usually workable because the counselor is in control of the situation and can see the patient's relief almost immediately.

Even as far back as 1910, Stekel (1967;107-109) addressed the schools role in dealing with suicide by saying:

The school is not responsible for the suicide of its pupils, but it also does not prevent these suicides. . . . The school should help its pupils in that period when their sand castles collapse and life brutally shows them the impossibility of realizing their fantasies. . . . Our teachers have failed to give our adolescent youth the horizon that their own psychological narrowness of outlook makes impossible. They have failed to convince the child of the triviality of personal experiences compared with the limitless abundance and infinity of life itself.

Education is the preparation of the child for adult life. We persuade ourselves that if we give the child "a beautiful childhood" we give him a store of memories rich enough to last him the rest of his life. We forget that an ear made sensitive to pure harmonies can be all the more grievously upset by any sudden disharmony, and that the finest effects can be secured by dissolving disharmonious chords. Every educator who encourages a child to forego a pleasure is on a higher ethical plane than one who leads him from pleasure to pleasure.

The school should seek to lead the child gently, so to speak, playfully, from the realm of fantasy into real life—not with empty formulas, accusatives and infinitives, algebraic lumber, and confusing masses of dates; not with harsh examinations and torturous grammar. It should know how to awaken the child's senses to the riches of life and nature, the imperishable masterpieces of ancient and modern art, and, indeed, all the achievements of human civilization. We cannot yet estimate what a tremendous role the greatest teacher of humanity—history—could play in this process. In sum, a child should be able to find that love in school which he is used to, for which he longs, and which he finds so lacking. . . . The teacher should be a friend to his pupils, and himself be a student of life. His most earnest endeavor and his proudest aim should be to break through the old imperatives, to present new aims, and to create free and independent human beings.

## **Chapter 3**

### **METHODOLOGY AND PROCEDURES**

This study was an attempt to gain information from selected secondary school principals in order to describe the role of the school in dealing with adolescent suicide as perceived by secondary school principals. The information gained from this study should be helpful in developing a model role for schools and school administrators in dealing with the adolescent suicide problem.

This chapter explains the procedure used in conducting this study. It is divided into four parts: (1) selection of the population, (2) data collection, (3) development of the survey instrument, and (4) treatment of the data.

#### **Selection of the Population**

Secondary school principals in the East Texas School Study Council were selected as the population of this study. The population included 193 secondary principals. The names and addresses of secondary principals were obtained from the master list of school administrators belonging to the East Texas Study Council. This list was on file in the office of the council at East Texas State University.

#### **Development of the Instrument**

The questionnaire was designed to answer the questions posed for the study. After a thorough search of the literature, and interviews with crisis counselors, school administrators, and professors of educational administration, a questionnaire for schools in dealing with adolescent suicide was developed.

The questionnaire was submitted to a number of college students, teachers, and professors at East Texas State University to test each question for clarity. A validation panel was then selected to review the questionnaire for its clarity and relevance to the study. The validation panel consisted of a distinguished panel of experts in the area of adolescent suicide and several secondary school principals who have suicide policies in their schools.

After all suggestions and comments had been received, the questionnaire was revised and the results formed a three-part questionnaire. The first part was designed to collect demographic information relative to the size of the district, years served in the district, grade levels included in the school, and the incidence of suicide or suicide attempt in the school system in the last two years. The second part of the questionnaire was designed to determine the desired and existing role of the school in a suicide prevention program. The third section of the questionnaire indicated the training principals considered necessary.

#### **Data Collection**

After the names of the principals in the population were obtained from the East Texas School Study Council, a letter explaining the nature and purpose of the study was sent along with the questionnaire. Each participant was assured of anonymity and confidentiality. A stamped, self-addressed envelope was provided for the return of the questionnaire. Each subject was allowed ten days to respond. At the end of ten days, seventy-one questionnaires were returned.

After recording the initial responses, a follow-up letter was sent to those not responding. After the follow-up letter, forty-three additional questionnaires were returned. The usable response was 114 (59 percent).

### **Treatment of the Data**

The data received were coded in order to facilitate computer analysis. Information on the distribution, variability, and central tendencies of the variables was recorded and represented by tables which can be found in Chapter 4. The data were also analyzed according to the following variables: incidence of suicide or attempted suicide, level of school, and size of school. The t-test was used to test for significance on the variables of incidence of suicide or attempted suicide and level of school. The one-way analysis of variance was used to test for significance on the variable of size of school. The results are in tabular form and presented in Chapter 4.

## Chapter 4

### PRESENTATION OF DATA

The purpose of this study was to determine the importance of actions which could be and are being taken by secondary school principals to help reduce the incidence of adolescent suicide. The study also identified the areas of training that secondary school principals deemed important in dealing with depressed students and other potential suicide victims. In addition, the study determined if there were any differences in responses from principals according to the variables of incidence of suicide, level of school, and school size. The information gained from this study should be helpful in developing a model role for schools and school administrators in dealing with the adolescent suicide problem.

The purpose of this chapter was to report and examine the data obtained from selected Texas secondary school principals. This chapter is organized into three sections for the purpose of presenting data. First, demographic data representing the responding secondary school principals are displayed. Second, data were organized to answer the research questions one through eight. Third, statistical analyses were conducted to determine if significant differences related to the variables of incidence of suicide or attempted suicide, level of school, and size of school. Responses to the following five categories of the instrument were utilized to test for significance on the variables: programs, identification procedures, reporting, follow-up actions by principal or designated other, and actions after suicide. Only those sections which showed a statistically significant difference are addressed in detail in this chapter. The t-test was used to test for significance on the variables of incidence of suicide or attempted suicide and level of school. The one-way analysis of variance technique was used to test for significance on the variable of school size.

#### Demographic Data

This section deals with the demographic section on the questionnaire. From a population of 193 principals, usable responses from 114 (59 percent) were received. A "no response" category was included for those questions which respondents did not answer. This section is divided into eight questions, and each question is addressed separately.

##### Question 1.

Question one under the section on demographic data on the questionnaire asks, "Including the present year, how many years have you been in this school district?" Table 1 reflects those years in the same school district. As can be noted from the table, over 50 percent of the principals who were questioned in this study had been in the district over ten years.

##### Question 2.

Question two asked, "How many years have you been a principal?" Table 2 shows the years that a respondent has been a principal. About 50 percent of the respondents have been a principal for less than five years.

Table 1

Principals' Responses to Years in District

| Years In District | Number    | Percent   |
|-------------------|-----------|-----------|
| 1-5               | 33        | 28.9      |
| 6-10              | 18        | 15.9      |
| 11-15             | 17        | 14.8      |
| 16 or More        | 44        | 38.6      |
| No Response       | 2         | 1.8       |
|                   | <hr/> 114 | <hr/> 100 |

Table 2.

Principals' Responses to Years as Principal

| Years As Principal | Number    | Percent   |
|--------------------|-----------|-----------|
| 1-5                | 56        | 49.1      |
| 6-10               | 30        | 26.3      |
| 11-15              | 12        | 10.7      |
| 16 or More         | 14        | 12.4      |
| No Response        | 2         | 1.8       |
|                    | <hr/> 114 | <hr/> 100 |

### Question 3.

Table 3 reflects the classification size of the school. The schools are divided into the U.I.L. athletic classifications of 1A to 5A. Schools are divided into classification sizes according to the following high school enrollment figures: 1A schools contain 134 students and below, 2A schools contain 135 to 274 students, 3A schools contain 275 to 649 students, 4A schools contain 650 to 1304 students, and 5A schools contain 1305 students and above. A high school is defined by the U.I.L. as a school that is a unit of a school district and that offers instruction in the ninth, tenth, eleventh, or twelfth grade or any combination thereof, whether all of the grades are offered instruction in the same building. The data shows that there are thirty schools are classified as 5A, twenty that are classified as 4A, thirty-eight that are classified as 3A, eighteen that are classified as 2A, and eight that are classified as 1A.

Table 3  
Number of Schools According  
to Classification Size

| Size | Number    | Percent   |
|------|-----------|-----------|
| 5A   | 30        | 26.3      |
| 4A   | 20        | 17.5      |
| 3A   | 38        | 33.3      |
| 2A   | 18        | 15.8      |
| 1A   | 8         | 7.0       |
|      | <hr/> 114 | <hr/> 100 |

### Question 4.

For the purpose of this study, schools are divided into middle/junior high schools and high schools. The breakdown of these data is reflected in Table 4. The data show that 46.5 percent of the principals were middle/junior high, 50 percent were high school, and 3.5 percent of the principals did not respond.

### Question 5.

Principals were asked to respond to a question concerning the incidence of a serious suicide in the district in the last two years. These data are listed by frequency and percentage according to the yes or no responses which were given. Data reflected in Table 5 reveal that 22.8 percent of the respondents had a suicide in their district. Almost 75 percent (73.7 percent) of the respondents did not have a suicide in their representative districts.

Table 4.

## Number of Principals by Level of School

| Grade                     | Number    | Percent   |
|---------------------------|-----------|-----------|
| Middle/Junior High School | 53        | 46.5      |
| High School               | 57        | 50.0      |
| No Response               | 4         | 3.5       |
|                           | <hr/> 114 | <hr/> 100 |

Table 5

## Incidence of Recent Suicide in School District

| Response    | Frequency | Percent   |
|-------------|-----------|-----------|
| Yes         | 26        | 22.8      |
| No          | 84        | 73.7      |
| No Response | 4         | 3.5       |
|             | <hr/> 114 | <hr/> 100 |

**Question 6.**

Principals were asked if there had been a suicide in the principal's school in the last two years. These data in Table 6 reflect that less than 10 percent of the respondents had a suicide in their respective schools in the last two years.

**Question 7.**

Principals were asked if there had been a suicide attempt in the last two years. The responses are recorded in Table 7.

Table 6

Incidence of Suicide in School  
in the Last Two Years

| Response    | Frequency | Percent   |
|-------------|-----------|-----------|
| Yes         | 8         | 7.0       |
| No          | 103       | 90.4      |
| No Response | 3         | 2.6       |
|             | <hr/> 114 | <hr/> 100 |

Table 7

Serious Suicide Attempts in the Last Two Years

| Response    | Frequency | Percent   |
|-------------|-----------|-----------|
| Yes         | 39        | 34.2      |
| No          | 74        | 64.9      |
| No Response | 1         | 0.9       |
|             | <hr/> 114 | <hr/> 100 |

**Question 8.**

Question eight under the demographic section dealt with the inservice programs school districts had concerning suicide. The data are reflected in Table 8.

Table 8

## Suicide Awareness Inservice Held in District

| Response    | Frequency | Percent   |
|-------------|-----------|-----------|
| Yes         | 35        | 30.7      |
| No          | 77        | 67.5      |
| No Response | 2         | 1.8       |
|             | <hr/> 114 | <hr/> 100 |

**Data Reported by Research Questions**

This section answers the research questions posed in chapter one. Each question is dealt with independently. The individual data are displayed for each item. To facilitate the reading and understanding of the tables, individual questions are listed before the tables in each section. Within the tables are corresponding numbers which relate to the individual questions. Then under each section, questions and/or components are listed in rank order. On research question two (program components) and research question three (identification procedures), the extent to which they were operational in schools is listed. Each of the research questions addressed a separate section on the questionnaire. The sections were as follows: policy, programs, identification procedures, reporting, follow-up actions by principal or designated other, linkages, actions after a suicide, and training necessary for principals.

**Research Question 1.**

The first research question was, "Is there a district board policy provision which deals with adolescent suicide in schools." Principals' responses are displayed in Table 9.

As can be noted from Table 9, few schools (less than 10 percent) had district policy provisions which address adolescent suicide. Over 90 percent of the schools did not have a district board policy provision.

Table 9

District Policy Addressing Suicide

| Response    | Frequency | Percent |
|-------------|-----------|---------|
| Yes         | 8         | 7.0     |
| No          | 103       | 90.4    |
| No Response | 3         | 2.6     |
|             | 114       | 100     |

#### Research Question 2.

The second research question was, "What components of a suicide prevention program are most desirable and to what extent are they presently being used?" Based on a review of the literature and discussions with experts, possible components of a total school suicide program were identified. From the viewpoint of a secondary principal, principals indicated the degree of importance of each component in a total school suicide program (Table 10). Also, the current status of each component in the principal's school was reported (Table 11). The following are the components to which principals responded in questionnaire order.

1. Development of school level policy which addresses adolescent suicide
2. Inservice training for all school personnel concerning healthy school climate
3. Formation of "Newcomers" program for students new to the district
4. Introduction of student curriculum which addresses suicide
5. Introduction of student curriculum which addresses stress management
6. Distribution of materials on the signs and symptoms of suicide
7. Inservice training for administrators dealing with identification of high risk students
8. Inservice training for teachers dealing with identification of high risk students
9. Inservice training for counselors dealing with identification of high risk students
10. Inservice training for non-professional personnel dealing with identification of high risk students
11. Formation of extra curricular "Student Awareness Program" to explain the facts about adolescent suicide
12. In-school referral process for identified high risk student
13. Formation of "Care Team" (professional personnel trained in crisis intervention)

The means of these components or items were computed and a rank order was es-

tablished. The extent of implementation in schools was also computed for these rank ordered components. This information is displayed in Table 12.

The major findings in this area are that inservice training items for professional personnel were ranked as the most important components, especially for counselors. It should also be noted that components one through eight were ranked as very important to extremely important. The data also show that the extent to which these components are operational is relatively low compared to the importance placed on them.

Table 10  
Program Components Displayed by Degree of Importance

| #of Responses | Question # | No Imp. |     | Little Imp. |      | Imp. |      | Very Imp. |      | Ext Imp. |      |
|---------------|------------|---------|-----|-------------|------|------|------|-----------|------|----------|------|
|               |            | #       | %   | #           | %    | #    | %    | #         | %    | #        | %    |
| 112           | 1.         | 1       | 0.9 | 6           | 5.4  | 60   | 53.6 | 36        | 32.1 | 9        | 8.0  |
| 112           | 2.         | 0       | 0.0 | 2           | 1.8  | 36   | 32.1 | 51        | 45.5 | 23       | 20.5 |
| 114           | 3.         | 1       | 0.9 | 12          | 10.5 | 55   | 48.2 | 31        | 27.2 | 15       | 13.2 |
| 114           | 4.         | 1       | 0.9 | 13          | 11.4 | 69   | 60.5 | 26        | 22.8 | 5        | 4.4  |
| 112           | 5.         | 0       | 0.0 | 6           | 5.4  | 54   | 48.2 | 41        | 36.6 | 11       | 9.8  |
| 112           | 6.         | 0       | 0.0 | 4           | 3.6  | 58   | 51.8 | 40        | 35.7 | 10       | 8.9  |
| 114           | 7.         | 0       | 0.0 | 7           | 6.1  | 39   | 34.2 | 39        | 34.2 | 29       | 25.4 |
| 113           | 8.         | 0       | 0.0 | 4           | 3.5  | 39   | 34.5 | 44        | 38.9 | 26       | 23.0 |
| 114           | 9.         | 0       | 0.0 | 0           | 0.0  | 25   | 21.9 | 48        | 42.1 | 41       | 36.0 |
| 112           | 10.        | 4       | 3.6 | 18          | 16.1 | 57   | 50.9 | 25        | 22.3 | 8        | 7.1  |
| 113           | 11.        | 3       | 2.7 | 14          | 12.4 | 59   | 52.2 | 27        | 23.9 | 10       | 8.8  |
| 114           | 12.        | 1       | 0.9 | 3           | 2.6  | 49   | 43.0 | 35        | 30.7 | 26       | 22.8 |
| 113           | 13.        | 1       | 0.9 | 11          | 9.7  | 42   | 37.2 | 42        | 37.2 | 17       | 15.0 |

Table 11  
Program Components Displayed by Operational Status

| #of Responses | Question # | In Our School |      | Not In Our School |      | Not Applicable |     |
|---------------|------------|---------------|------|-------------------|------|----------------|-----|
|               |            | #             | %    | #                 | %    | #              | %   |
| 109           | 1.         | 17            | 15.6 | 91                | 83.0 | 1              | 0.9 |
| 107           | 2.         | 47            | 43.9 | 60                | 56.1 | 0              | 0.0 |
| 111           | 3.         | 28            | 25.2 | 82                | 73.9 | 1              | 0.9 |
| 110           | 4.         | 18            | 16.4 | 91                | 82.7 | 1              | 0.9 |
| 110           | 5.         | 24            | 21.8 | 85                | 77.3 | 1              | 0.9 |
| 109           | 6.         | 41            | 37.6 | 68                | 62.4 | 0              | 0.0 |
| 109           | 7.         | 26            | 23.9 | 83                | 76.1 | 0              | 0.0 |
| 108           | 8.         | 25            | 23.1 | 83                | 76.9 | 0              | 0.0 |
| 108           | 9.         | 52            | 48.1 | 56                | 51.9 | 0              | 0.0 |
| 108           | 10.        | 12            | 11.1 | 90                | 83.3 | 6              | 5.6 |
| 109           | 11.        | 19            | 17.4 | 89                | 81.7 | 1              | 0.9 |
| 109           | 12.        | 37            | 33.9 | 72                | 66.1 | 0              | 0.0 |
| 109           | 13.        | 13            | 11.9 | 94                | 86.2 | 2              | 1.8 |

Table 12

Rank Order of Responses by Principals by Importance and Extent  
of Implementation of Program Components

| Question                                                                                                    | Mean  | % operational in school |
|-------------------------------------------------------------------------------------------------------------|-------|-------------------------|
| 1. Inservice training for counselors dealing with identification of high risk students                      | 4.140 | 48.1                    |
| 2. Inservice training for all school personnel concerning healthy school climate                            | 3.848 | 43.9                    |
| 3. Inservice training for teachers dealing with identification of high risk students                        | 3.814 | 23.1                    |
| 4. Inservice training for administrators dealing with identification of high risk students                  | 3.789 | 23.9                    |
| 5. In-school referral process for identified high risk students                                             | 3.719 | 33.9                    |
| 6. Formation of "CareTeam" (professional personnel trained in crisis intervention)                          | 3.558 | 11.9                    |
| 7. Introduction of student curriculum which addresses stress management                                     | 3.509 | 21.8                    |
| 8. Distribution of materials on the signs and symptoms of suicide                                           | 3.500 | 37.6                    |
| 9. Formation of "Newcomers" program for students new to the district.                                       | 3.412 | 25.2                    |
| 10. Development of school level policy which addresses adolescent suicide                                   | 3.411 | 15.6                    |
| 11. Formation of extra curricular "Student Awareness Program" to explain the facts about adolescent suicide | 3.239 | 17.4                    |
| 12. Introduction of student curriculum which addresses suicide                                              | 3.184 | 16.4                    |
| 13. Inservice training for non-professional personnel dealing with identification of high risk students     | 3.134 | 11.1                    |

### Research Question 3.

The third research question was, "What methods are most desirable and are presently being used in the school to identify high risk students?" Identification of high risk students is a major factor in dealing with the adolescent suicide problem. The following are procedures whereby trained individuals identify potentially suicidal students. Principals responded to the importance of the following means of identification. Responses were also tabulated as to whether or not this process was operational in that principal's school. These data can be found in Tables 13 and 14. Listed below are six different means of identification in the order they appeared on the questionnaire.

1. Observation of student behaviors and situations affecting mental health by principals and assistant principals
2. Observation of student behaviors and situations affecting mental health by teachers
3. Observation of student behaviors and situations affecting mental health by counselors

4. Observation of student behaviors and situations affecting mental health by non-professionals
5. Observation of student behaviors and situations affecting mental health by students (peers)
6. Survey of general student population by means of a self-evaluation survey

The means of the importance rating of these procedures were computed and a rank order was established. The extent of implementation in schools was also displayed for rank ordered procedures. This information is displayed in Table 15.

Table 13.

Identification Procedures Reported by Degree of Importance

| #of<br>Responses | Question<br># | No Imp |     | Little Imp |      | Imp. |      | Very Imp. |      | Ext Imp. |      |
|------------------|---------------|--------|-----|------------|------|------|------|-----------|------|----------|------|
|                  |               | #      | %   | #          | %    | #    | %    | #         | %    | #        | %    |
| 113              | 1.            | 0      | 0.0 | 1          | 9    | 43   | 38.1 | 50        | 44.2 | 19       | 16.8 |
| 113              | 2.            | 0      | 0.0 | 0          | 0.0  | 39   | 34.5 | 51        | 45.1 | 23       | 20.4 |
| 113              | 3.            | 0      | 0.0 | 1          | 0.9  | 34   | 30.1 | 47        | 41.6 | 31       | 27.4 |
| 112              | 4.            | 3      | 2.7 | 17         | 15.2 | 52   | 46.4 | 33        | 29.5 | 7        | 6.3  |
| 113              | 5.            | 0      | 0.0 | 9          | 8.0  | 46   | 40.7 | 42        | 37.2 | 16       | 14.2 |
| 114              | 6.            | 5      | 4.4 | 27         | 23.7 | 47   | 41.2 | 29        | 25.4 | 6        | 5.3  |

Table 14

Operational Status of Identification Procedures

| #of<br>Responses | Question<br># | In Our School |      | Not In Our School |      | Not Applicable |     |
|------------------|---------------|---------------|------|-------------------|------|----------------|-----|
|                  |               | #             | %    | #                 | %    | #              | %   |
| 110              | 1.            | 72            | 65.5 | 38                | 34.5 | 0              | 0.0 |
| 110              | 2.            | 74            | 67.3 | 36                | 32.7 | 0              | 0.0 |
| 110              | 3.            | 76            | 69.1 | 32                | 29.1 | 2              | 1.8 |
| 109              | 4.            | 36            | 33.0 | 71                | 65.1 | 2              | 1.8 |
| 109              | 5.            | 42            | 38.5 | 66                | 60.6 | 1              | 0.9 |
| 110              | 6.            | 13            | 11.8 | 96                | 87.3 | 1              | 0.9 |

Table 15.

Rank Order of Identification Procedures by Principals by  
Importance and Extent of Implementation in Schools

| Question                                                                                                         | Mean  | % operational in schools |
|------------------------------------------------------------------------------------------------------------------|-------|--------------------------|
| 1. Observation of student behaviors and situation affecting mental health by counselors                          | 3.956 | 69.1                     |
| 2. Observation of student behaviors and situation affecting mental health by teachers                            | 3.858 | 67.3                     |
| 3. Observation of student behaviors and situation affecting mental health by principals and assistant principals | 3.770 | 65.5                     |
| 4. Observation of student behaviors and situation affecting mental health by students (peers)                    | 3.575 | 38.5                     |
| 5. Observation of student behaviors and situation affecting mental health by non-professionals                   | 3.214 | 33.0                     |
| 6. Survey of general student population by means of a self-evaluation survey                                     | 3.035 | 11.8                     |

The four top ranked procedures exceeded a mean of 3.5 (very important). A sharp drop in operational status is noted for procedures not involving professional staff.

#### Research Question 4.

The fourth research question was, "What importance is placed on informing certain school official(s) in secondary schools after high risk students have been identified?" After high risk students have been identified, they should be reported to the proper school official(s). From the viewpoint of a secondary principal, principals responded to the importance of reporting to the following school official(s). These data are found in Table 16. Listed below are five school officials and a care team of professionals in the order they appeared on the questionnaire.

1. principal or assistant principal
2. counselor
3. designated teacher
4. "Care Team"
5. school nurse

In the section on reporting, the respondents also rated the proper school official(s) who might need to be notified if a student were identified as suicidal. The means of these were computed and a rank order was established. This information is displayed in Table 17.

A counselor is considered as the most important official in the school to be notified if there is a potentially suicidal student. The principal or assistant principal was considered as the second most important in the school to be notified.

Table 16.  
Reporting By Degree Of Importance

| #of Responses | Question # | No Imp. |     | Little Imp. |     | Imp. |      | Very Imp. |      | Ext Imp. |      |
|---------------|------------|---------|-----|-------------|-----|------|------|-----------|------|----------|------|
|               |            | #       | %   | #           | %   | #    | %    | #         | %    | #        | %    |
| 114           | 1.         | 0       | 0.0 | 0           | 0.0 | 12   | 10.5 | 39        | 34.2 | 63       | 55.3 |
| 113           | 2.         | 0       | 0.0 | 0           | 0.0 | 05   | 4.4  | 33        | 29.2 | 75       | 66.4 |
| 114           | 3.         | 1       | 0.9 | 3           | 2.6 | 30   | 26.3 | 37        | 32.5 | 43       | 37.7 |
| 108           | 4.         | 5       | 4.6 | 6           | 5.6 | 31   | 28.7 | 28        | 25.9 | 38       | 35.2 |
| 113           | 5.         | 0       | 0.0 | 6           | 5.3 | 21   | 18.6 | 40        | 35.4 | 46       | 40.7 |

Table 17.  
Rank Order Of Reporting To Proper School Official(s)

| School Official                     | Mean  |
|-------------------------------------|-------|
| 1. Counselor                        | 4.619 |
| 2. Principal or assistant principal | 4.447 |
| 3. School nurse                     | 4.115 |
| 4. Designated teacher               | 4.035 |
| 5. "Care Team"                      | 3.815 |

#### Research Question 5.

The fifth research question asked, "What follow-up actions should be taken by the principal, or other designated person, after receiving a report of a potentially suicidal student?" After receiving a report of a potentially suicidal student, the principal or a designated other person should take some kind of follow-up action. Several options were listed on the questionnaire and principals responded to the importance of each item, assuming each option was available in their school. The degree of importance can be found in Table 18. The following is a list of the twelve options. They are listed below in the same order as on the questionnaire.

1. Notify parents
2. Document student's actions
3. Counsel privately with student
4. Counsel privately with parent
5. Counsel with student and parent together
6. Notify "Care Team"
7. Refer parent to local physician

Table 18

## Follow-Up Actions By Principal Or Designated Other

| # of Responses | Question # | No Imp. |     | Little Imp. |      | Imp. |      | Very Imp. |      | Ext Imp. |      |
|----------------|------------|---------|-----|-------------|------|------|------|-----------|------|----------|------|
|                |            | #       | %   | #           | %    | #    | %    | #         | %    | #        | %    |
| 113            | 1.         | 0       | 0.0 | 0           | 0.0  | 10   | 8.8  | 27        | 23.9 | 76       | 67.3 |
| 111            | 2.         | 0       | 0.0 | 0           | 0.0  | 20   | 18.0 | 52        | 46.8 | 39       | 35.1 |
| 112            | 3.         | 0       | 0.0 | 0           | 0.0  | 7    | 6.3  | 40        | 35.7 | 65       | 58.0 |
| 112            | 4.         | 0       | 0.0 | 1           | 0.9  | 11   | 9.8  | 53        | 47.3 | 47       | 42.0 |
| 111            | 5.         | 0       | 0.0 | 8           | 7.2  | 26   | 23.4 | 39        | 35.1 | 38       | 34.2 |
| 105            | 6.         | 5       | 4.8 | 7           | 6.7  | 34   | 32.4 | 30        | 28.6 | 29       | 27.6 |
| 109            | 7.         | 2       | 1.8 | 15          | 13.8 | 28   | 25.7 | 41        | 37.6 | 23       | 21.1 |
| 110            | 8.         | 0       | 0.0 | 2           | 1.8  | 16   | 14.5 | 34        | 30.9 | 58       | 52.7 |
| 110            | 9.         | 1       | 0.9 | 3           | 2.7  | 19   | 17.3 | 38        | 34.5 | 49       | 44.5 |
| 110            | 10.        | 4       | 3.6 | 8           | 7.3  | 33   | 30.0 | 42        | 38.2 | 23       | 20.9 |
| 111            | 11.        | 0       | 0.0 | 3           | 2.7  | 15   | 13.5 | 43        | 38.7 | 50       | 45.0 |
| 109            | 12.        | 6       | 5.5 | 12          | 11.0 | 48   | 44.0 | 29        | 26.6 | 14       | 12.8 |

8. Refer parent to suicide and crisis center
9. Refer parent to local mental health professional
10. Refer parent to minister
11. Refer student to school counselor for personal counseling
12. Refer student to school nurse for personal counseling

The means for these options were computed and a rank order was established. This information is displayed in Table 19.

Table 19.

## Rank Order of Follow-Up Actions by Principal or Designated Other

| Option                                                       | Mean  |
|--------------------------------------------------------------|-------|
| 1. Notify parent                                             | 4.584 |
| 2. Counsel privately with student                            | 4.518 |
| 3. Refer parent to suicide and crisis center                 | 4.345 |
| 4. Counsel privately with parent                             | 4.304 |
| 5. Refer student to school counselor for personal counseling | 4.261 |
| 6. Refer parent to local mental health professional          | 4.191 |
| 7. Document student's actions                                | 4.171 |
| 8. Counsel with student and parent together                  | 3.964 |
| 9. Notify "Care Team"                                        | 3.676 |
| 10. Refer parent to minister                                 | 3.655 |
| 11. Refer parent to local physician                          | 3.624 |
| 12. Refer student to school nurse for personal counseling    | 3.303 |

Principals responded that notification of the parent was the most important action that could be taken if a student was identified as a potential suicide victim. The principals also thought it was extremely important to counsel with the student privately to determine the seriousness of the situation. The importance of follow-up actions to principals is demonstrated by all but one item being rated as very important or extremely important.

#### Research Question 6.

Research question six asked, "What linkages with community resources that can help in dealing with adolescent suicide are accessible to secondary schools?" Out-of-school linkages will be valuable sources for principals when they have a possible suicidal student or a suicide. The out-of-school linkages were listed, and principals responded if they had reasonable access to them. Table 20 reflects the responses given in the order listed on the questionnaire.

Table 20  
Accessibility Of Linkages

| #of Responses | Linkage                                 | Has Access |      | No Access |      |
|---------------|-----------------------------------------|------------|------|-----------|------|
|               |                                         | #          | %    | #         | %    |
| 114           | Local doctor                            | 90         | 78.9 | 24        | 21.1 |
| 114           | Local mental health professional        | 71         | 62.3 | 43        | 37.7 |
| 114           | Local hospital                          | 63         | 55.3 | 51        | 44.7 |
| 114           | Suicide and Crisis Center               | 43         | 37.7 | 71        | 62.3 |
| 114           | American Red Cross                      | 25         | 21.9 | 89        | 78.1 |
| 114           | Al-Anon                                 | 27         | 23.7 | 87        | 76.3 |
| 114           | Alcoholics Anonymous                    | 33         | 28.9 | 81        | 71.1 |
| 114           | YMCA                                    | 18         | 15.8 | 96        | 84.2 |
| 114           | Child Welfare Department                | 93         | 81.6 | 21        | 18.4 |
| 114           | Local minister                          | 98         | 86.0 | 16        | 14.0 |
| 114           | Grief counselor                         | 7          | 6.1  | 107       | 93.9 |
| 114           | Police Department                       | 87         | 76.3 | 27        | 23.7 |
| 114           | University Counseling Department        | 11         | 9.6  | 46        | 40.4 |
| 114           | Mental Health and Mental Retardation Ag | 68         | 59.6 | 46        | 40.4 |
| 114           | Alateen                                 | 22         | 19.3 | 92        | 80.7 |
| 114           | YWCA                                    | 13         | 11.4 | 101       | 88.6 |
| 114           | Texas Department of Health              | 58         | 50.9 | 56        | 49.1 |

Each principal responded to accessibility to out-of-school linkages. These responses are listed in rank order by their accessibility in Table 21.

Linkages one through eight were accessible to over fifty percent of the schools. There was a sharp drop in the accessibility of the following nine linkages.

Table 21

## Linkages Rank Ordered by Extent of Accessibility

| Linkage                                        | Percent Accessible |
|------------------------------------------------|--------------------|
| 1. Local minister                              | 86.0               |
| 2. Child Welfare Department                    | 81.6               |
| 3. Local doctor                                | 78.9               |
| 4. Police Department                           | 76.3               |
| 5. Local mental health professional            | 62.3               |
| 6. Mental Health and Mental Retardation Agency | 59.6               |
| 7. Local hospital                              | 55.3               |
| 8. Texas Department of Health                  | 50.9               |
| 9. Suicide and Crisis Center                   | 37.7               |
| 10. Alcoholics Anonymous                       | 28.9               |
| 11. Al-Anon                                    | 23.7               |
| 12. American Red Cross                         | 21.9               |
| 13. Alateen                                    | 19.3               |
| 14. YMCA                                       | 15.8               |
| 15. YWCA                                       | 11.4               |
| 16. University Counseling Department           | 9.6                |
| 17. Grief Counselor                            | 6.1                |

**Research Question 7.**

Research question seven asked, "What importance is placed on certain actions which could be taken in secondary schools after a student suicide occurs?" Actions and procedures that various authorities suggested could be taken by schools after a student suicide were listed for principals to respond to their importance in a total school suicide program. The following are the possible actions to which principals responded. The actions are listed in the order that they appeared on the questionnaire and are addressed in Table 22.

1. Provide for mobilization of "Care Team"
2. Provide for a general assembly to address concerns of students and to dismiss any rumors surrounding the suicide
3. Provide time for individual classroom discussion
4. Provide educational materials to students and teachers
5. Provide expert speaker to address the topic of suicide for students, teachers, and parents
6. Provide individual counseling to students by qualified counselor
7. Provide individual counseling to teachers by qualified counselor
8. Provide group counseling to students by qualified counselor
9. Provide group counseling to teachers by qualified counselor
10. Provide time for peer counseling monitored by qualified counselor
11. Provide follow up counseling for close friends of suicide victim

Table 22

## Actions After Suicide By Degree Of Importance

| #of Responses | Question # | No Imp |     | Little Imp |      | Imp |      | Very Imp |      | Ext Imp |      |
|---------------|------------|--------|-----|------------|------|-----|------|----------|------|---------|------|
|               |            | #      | %   | #          | %    | #   | %    | #        | %    | #       | %    |
| 105           | 1          | 4      | 3.8 | 9          | 8.6  | 43  | 41.0 | 36       | 34.3 | 13      | 12.4 |
| 107           | 2          | 8      | 7.5 | 33         | 30.8 | 35  | 32.7 | 25       | 23.4 | 6       | 5.6  |
| 111           | 3          | 2      | 1.8 | 10         | 9.0  | 41  | 36.9 | 37       | 33.3 | 21      | 18.9 |
| 109           | 4          | 1      | 0.9 | 2          | 1.8  | 40  | 36.7 | 39       | 35.8 | 27      | 24.8 |
| 108           | 5          | 2      | 1.9 | 8          | 7.4  | 40  | 37.0 | 37       | 34.3 | 21      | 19.4 |
| 110           | 6          | 0      | 0.0 | 2          | 1.8  | 17  | 15.5 | 45       | 40.9 | 46      | 41.8 |
| 109           | 7          | 1      | 0.9 | 5          | 4.6  | 31  | 28.4 | 40       | 36.7 | 32      | 29.4 |
| 109           | 8          | 0      | 0.0 | 7          | 6.4  | 35  | 32.1 | 37       | 33.9 | 30      | 27.5 |
| 108           | 9          | 1      | 0.9 | 9          | 8.3  | 38  | 35.2 | 33       | 30.6 | 27      | 25.0 |
| 109           | 10         | 3      | 2.8 | 24         | 22.0 | 32  | 29.4 | 38       | 34.9 | 12      | 11.0 |
| 109           | 11         | 1      | 0.9 | 4          | 3.7  | 26  | 23.9 | 41       | 37.6 | 37      | 33.9 |

The means of importance ratings for these actions were computed and a rank order was established. The actions are listed in rank order and displayed in Table 23.

The counselor was again seen as the key person to be involved in the school when there was a student suicide. Principals ranked a general assembly as the least important action which could be taken when there was a student suicide.

### Research Question 8.

Research question eight inquired, "What topics need to be addressed in a suicide training program that would be appropriate for secondary principals?" There were nine topics listed and a tenth place for principals to add a topic not listed. Even though "other" was marked twice, there were no other topics listed by principals. The following are the topics to which principals responded. The topics are listed in the order they appeared on the questionnaire and are reflected in Table 24.

1. Development of school level policy dealing with suicide
2. Development of school procedures dealing with suicide
3. Formation of "Newcomers" program and guidelines
4. Formation of "Care Team" program and guidelines
5. Curriculum development dealing with stress management and suicide
6. Warning signs of suicide
7. Grief counseling procedures
8. Referral procedures
9. Information about agencies which deal with adolescent suicide
10. Other

The topics of training were rank ordered by the percent of respondents who indicated principals needed training in that area. This information is displayed in Table 25.

Principals rated training in the area of warning signs and symptoms of suicide as the highest. It should be noted that the development of school procedures dealing with suicide and referral procedures were considered training needs for more than 70 percent of the responding principals.

Table 23

## Actions After Suicide by Rank Order

| Action or Procedure                                                                                                     | Mean  |
|-------------------------------------------------------------------------------------------------------------------------|-------|
| 1. Provide individual counseling to students by qualified counselor                                                     | 4.227 |
| 2. Provide follow up counseling for close friends of suicide victim                                                     | 4.000 |
| 3. Provide individual counseling to teachers by qualified counselor                                                     | 3.890 |
| 4. Provide group counseling to students by qualified counselor                                                          | 3.826 |
| 5. Provide educational materials to students and teachers                                                               | 3.817 |
| 6. Provide group counseling to teachers by qualified counselor                                                          | 3.704 |
| 7. Provide expert speaker to address the topic of suicide<br>for students, teachers, and parents                        | 3.620 |
| 8. Provide time for individual classroom discussion                                                                     | 3.586 |
| 9. Provide for mobilization of "Care Team"                                                                              | 3.429 |
| 10. Provide time for peer counseling monitored by qualified counselor                                                   | 3.294 |
| 11. Provide for a general assembly to address concerns of students<br>and to dismiss any rumors surrounding the suicide | 2.888 |

Table 24

## Training Necessary For Principals

| #of<br>Responses | Question<br># | Need Training |      | Do Not Need Training |      |
|------------------|---------------|---------------|------|----------------------|------|
|                  |               | #             | %    | #                    | %    |
| 113              | 1.            | 68            | 60.2 | 45                   | 39.8 |
| 113              | 2.            | 89            | 78.8 | 24                   | 21.2 |
| 113              | 3.            | 57            | 50.4 | 56                   | 49.6 |
| 113              | 4.            | 60            | 53.1 | 53                   | 46.9 |
| 113              | 5.            | 77            | 68.1 | 36                   | 31.9 |
| 113              | 6.            | 101           | 89.4 | 12                   | 10.6 |
| 113              | 7.            | 54            | 47.8 | 59                   | 52.2 |
| 113              | 8.            | 80            | 70.8 | 33                   | 29.2 |
| 113              | 9.            | 77            | 68.1 | 36                   | 31.9 |
| 113              | 10.           | 2             | 1.8  | 111                  | 98.2 |

Table 25

### Training Needed for Principals Listed by Rank Order and Percent

| Topic Of Training                                                    | Percent Who Said Principals Need Training |
|----------------------------------------------------------------------|-------------------------------------------|
| 1. Warning signs of suicide                                          | 89.4                                      |
| 2. Development of school procedures dealing with suicide             | 78.8                                      |
| 3. Referral procedures                                               | 70.8                                      |
| 4. Curriculum development dealing with stress management and suicide | 68.1                                      |
| 5. Information about agencies which deal with adolescent suicide     | 68.1                                      |
| 6. Development of school level policy dealing with suicide           | 60.2                                      |
| 7. Formation of "Care Team" program and guidelines                   | 53.1                                      |
| 8. Formation of "Newcomers" program and guidelines                   | 50.4                                      |
| 9. Grief counseling procedures                                       | 47.8                                      |
| 10. Other                                                            | 1.8                                       |

#### Test of Research Questions By Variables

Statistical analyses were conducted to determine if significant differences existed due to the variables of: incidence of suicide or suicide attempt, level of school, and school size. The following five categories were utilized in testing the variables for significance: programs, identification procedures, reporting, follow-up actions by principals or designated other, and actions after suicide. Only those sections which showed a statistically significant difference are addressed in detail in this chapter.

#### Incidence of Suicide or Attempted Suicide

*Suicide In District Compared To No Suicide In District.* The data including frequency and percent for the question "Has there been a suicide in your school district in the last two years?" were displayed in Table 5.

Less than one-fourth of the principals surveyed showed they had a suicide in their district in the last two years. There was no significant difference found in any of the areas tested for significance. Table 26 shows the findings for each category.

*Suicide In School Compared To No Suicide In School.* The raw data including frequency and percent for the question "Has there been a suicide in your school in the last two years?" is found in Table 6. Less than ten percent of the principals said they have had a suicide in the last two years. There was no significant difference found in any of the areas tested for significance. Table 27 shows the findings for each category.

Table 26  
T-Test Comparing Suicide in District  
to No Suicide in District

|                                  | N  | X     | T Value | Significance | Level of Sig. |
|----------------------------------|----|-------|---------|--------------|---------------|
| <b>Programs</b>                  |    |       |         |              |               |
| Suicide                          | 26 | 46.50 |         |              |               |
| No Suicide                       | 84 | 45.43 | 0.60    | No           | 0.549         |
| <b>Identification Procedures</b> |    |       |         |              |               |
| Suicide                          | 26 | 21.38 |         |              |               |
| No Suicide                       | 84 | 21.07 | 0.33    | No           | 0.743         |
| <b>Reporting</b>                 |    |       |         |              |               |
| Suicide                          | 26 | 21.38 |         |              |               |
| No Suicide                       | 84 | 20.44 | 1.26    | No           | 0.211         |
| <b>Follow Up Actions</b>         |    |       |         |              |               |
| Suicide                          | 26 | 46.46 |         |              |               |
| No Suicide                       | 83 | 47.82 | -0.81   | No           | 0.418         |
| <b>Actions After Suicide</b>     |    |       |         |              |               |
| Suicide                          | 24 | 38.13 |         |              |               |
| No Suicide                       | 83 | 39.61 | -0.82   | No           | 0.413         |

Table 27  
T-Test Comparing Suicide in School  
to No Suicide in School

|                                  | N   | X     | T Value | Significance | Level of Sig. |
|----------------------------------|-----|-------|---------|--------------|---------------|
| <b>Programs</b>                  |     |       |         |              |               |
| Suicide                          | 8   | 48.75 |         |              |               |
| No Suicide                       | 103 | 45.54 | 1.10    | No           | 0.273         |
| <b>Identification Procedures</b> |     |       |         |              |               |
| Suicide                          | 8   | 22.25 |         |              |               |
| No Suicide                       | 103 | 21.07 | 0.76    | No           | 0.447         |
| <b>Reporting</b>                 |     |       |         |              |               |
| Suicide                          | 8   | 21.63 |         |              |               |
| No Suicide                       | 103 | 20.63 | 0.80    | No           | 0.423         |
| <b>Follow Up Actions</b>         |     |       |         |              |               |
| Suicide                          | 8   | 47.13 |         |              |               |
| No Suicide                       | 102 | 47.44 | -0.12   | No           | 0.908         |
| <b>Actions After Suicide</b>     |     |       |         |              |               |
| Suicide                          | 8   | 38.13 |         |              |               |
| No Suicide                       | 100 | 39.45 | -0.46   | No           | 0.646         |

*Suicide Attempt Compared To No Suicide Attempt In School.* The raw data including frequency and percent for the question "Has there been a serious suicide attempt in your school in the last two years?" were reported in Table 7.

There was a significant difference found in the area of program components which could be used in a school. Table 28 displays the findings for each category.

Table 28

T-Test Comparing Suicide Attempt to No Suicide Attempt

|                           | N  | X     | T Value | Significance | Level of Sig. |
|---------------------------|----|-------|---------|--------------|---------------|
| Programs                  |    |       |         |              |               |
| Attempt                   | 39 | 48.49 |         |              |               |
| No Attempt                | 74 | 44.46 | 2.65    | Yes          | 0.009         |
| Identification Procedures |    |       |         |              |               |
| Attempt                   | 39 | 22.08 |         |              |               |
| No Attempt                | 74 | 20.74 | 1.62    | No           | 0.108         |
| Reporting                 |    |       |         |              |               |
| Attempt                   | 39 | 21.10 |         |              |               |
| No Attempt                | 74 | 20.58 | 0.78    | No           | 0.435         |
| Follow-Up Actions         |    |       |         |              |               |
| Attempt                   | 39 | 47.62 |         |              |               |
| No Attempt                | 73 | 47.37 | 0.17    | No           | 0.867         |
| Actions After Suicide     |    |       |         |              |               |
| Attempt                   | 38 | 41.00 |         |              |               |
| No Attempt                | 72 | 38.51 | 1.61    | No           | 0.110         |

A significant difference in the area of programs was found. Table 29 shows the program components and individual levels of significance. There was a significant difference in the responses of question 4, 5, 6, 12, and 13. While there are five areas of significance, it should be noted that in eight areas there was no significance. In all cases where there was a significant difference in answers, principals who had a serious suicide attempt rated components of a suicide program as more important than those who did not. All questions were rated as more important by principals who had a serious suicide attempt except question 3 which addresses a "Newcomers" program.

#### Level of School

The data including number and percentage for the question concerning the grade level in each school can be found in Table 4. The level of the school was almost equally distributed. There was a significant difference found in the area of reporting procedures which could be used in a school. Table 30 shows the findings for each category.

Table 29

**Program Components: T-Test Comparing Suicide Attempts to No Suicide Attempts**

| Question                                                                                                     | Attempt | No Attempt | T Value | Significance | Level of Sig. |
|--------------------------------------------------------------------------------------------------------------|---------|------------|---------|--------------|---------------|
| 1. Development of school level policy which addresses adolescent suicide.                                    | 3.5789  | 3.3288     | 1.67    | No           | 0.098         |
| 2. Inservice training for all school personnel concerning healthy school climate.                            | 3.9231  | 3.8056     | 0.77    | No           | 0.442         |
| 3. Formation of "Newcomers" program for students new to the district.                                        | 3.3590  | 3.4459     | -0.50   | No           | 0.621         |
| 4. Introduction of student curriculum which addresses suicide.                                               | 3.4103  | 3.0676     | 2.44    | Yes          | 0.016         |
| 5. Introduction of student curriculum which addresses stress management.                                     | 3.7179  | 3.3889     | 2.25    | Yes          | 0.026         |
| 6. Distribution of materials on the signs and symptoms of suicide.                                           | 3.7436  | 3.3611     | 2.78    | Yes          | 0.006         |
| 7. Inservice training for administrators dealing with identification of high risk students.                  | 3.9487  | 3.7027     | 1.39    | No           | 0.169         |
| 8. Inservice training for teachers dealing with identification of high risk students.                        | 4.0000  | 3.7123     | 1.76    | No           | 0.082         |
| 9. Inservice training for counselors dealing with identification of high risk students.                      | 4.3077  | 4.0541     | 1.71    | No           | 0.089         |
| 10. Inservice training for non-professional personnel dealing with identification of high risk students.     | 3.2821  | 3.0556     | 1.27    | No           | 0.207         |
| 11. Formation of extra curricular "Student Awareness Program" to explain the facts about adolescent suicide. | 3.4615  | 3.1233     | 1.96    | No           | 0.053         |
| 12. In-school referral process for identified high risk students.                                            | 4.0513  | 3.5405     | 3.04    | Yes          | 0.003         |
| 13. Formation of "Care Team" (professional personnel trained in crisis intervention).                        | 3.7949  | 3.4247     | 2.11    | Yes          | 0.037         |

Table 30

T-Test Comparing Responses of Middle/Junior High  
Principals to High School Principals

|                                  | N  | X     | T Value | Significance | Level of Sig. |
|----------------------------------|----|-------|---------|--------------|---------------|
| <b>Programs</b>                  |    |       |         |              |               |
| Middle/Jr. High                  | 53 | 46.40 |         |              |               |
| High School                      | 57 | 45.58 | 0.55    | No           | 0.587         |
| <b>Identification Procedures</b> |    |       |         |              |               |
| Middle/Jr. High                  | 53 | 21.45 |         |              |               |
| High School                      | 57 | 20.95 | 0.63    | No           | 0.531         |
| <b>Reporting</b>                 |    |       |         |              |               |
| Middle/Jr. High                  | 53 | 21.57 |         |              |               |
| High School                      | 57 | 20.09 | 2.35    | Yes          | 0.021         |
| <b>Follow-Up Actions</b>         |    |       |         |              |               |
| Middle/Jr. High                  | 52 | 48.67 |         |              |               |
| High School                      | 57 | 46.40 | 1.64    | No           | 0.105         |
| <b>Actions After Suicide</b>     |    |       |         |              |               |
| Middle/Jr. High                  | 52 | 39.56 |         |              |               |
| High School                      | 55 | 39.02 | 0.36    | No           | 0.718         |

Because there was a significant difference in the area of reporting, Table 31 shows the reporting components. The individual levels of significance can also be found in Table 31.

Table 31

T- Test Results Comparing Responses of Middle/Junior  
High Principals to High School Principals on  
Reporting To Proper School Official(s)

| Official                            | Jr. High | High School | T Value | Significance | Level of Sig. |
|-------------------------------------|----------|-------------|---------|--------------|---------------|
| 1. Principal or assistant principal | 4.5472   | 4.3860      | 1.26    | No           | 0.211         |
| 2. Counselor                        | 4.6792   | 4.5536      | 1.14    | No           | 0.257         |
| 3. Designated teacher               | 4.3396   | 3.7895      | 3.28    | Yes          | 0.001         |
| 4. "Care Team"                      | 3.8824   | 3.7925      | 0.42    | No           | 0.679         |
| 5. School nurse                     | 4.3462   | 3.9123      | 2.55    | Yes          | 0.012         |

We note that there is a significant difference in responses between the middle/junior high and high school principals on designated teacher and school nurse. In both cases, middle/junior high principals thought it was more important for potential suicides to be reported to them than did high school principals.

### Size Of School

The data including frequency and percent for the question concerning the size of school district are found in Table 32 as well as an analysis of responses by district size utilizing a one-way analysis of variance technique.

Table 32  
ANOVA Comparing Responses By District Size

|                                                    | N=30<br>5A | N=20<br>4A | N=38<br>3A | N=18<br>2A | N=8<br>1A | F Ratio | Significance | Level of Sig. |
|----------------------------------------------------|------------|------------|------------|------------|-----------|---------|--------------|---------------|
| Programs                                           | 47.03      | 47.65      | 46.16      | 44.39      | 38.88     | 2.2803  | No           | .0653         |
| Identification Procedures                          | 21.60      | 22.20      | 20.74      | 20.72      | 20.75     | .5459   | No           | .7024         |
| Reporting                                          | 22.03      | 21.10      | 20.53      | 19.78      | 18.38     | 2.7481  | Yes          | .0319         |
| Follow-Up Actions By Principal Or Designated Other | 47.79      | 49.65      | 47.08      | 46.22      | 45.50     | .7517   | No           | .5590         |
| Actions After Suicide                              | 40.29      | 39.95      | 38.92      | 38.12      | 40.13     | .2810   | No           | .8897         |

There was a significance difference in the area of reporting to a proper school official after a high risk student is identified. However, no significance was found for the other four areas. Table 33 indicates where significant differences were found in responses by principals to the importance of reporting potential suicides to specified school officials.

It should be noted that the two areas of significance lie with the designated teacher and the school nurse. The larger schools thought it to be more important to contact these two professionals than did the small schools. This significance is probably due to school size in that the larger schools tend to have more staff.

Chapter 5 completes the study. It reports the (1) Summary of the Study, (2) Summary of the Findings and Conclusions, and (3) Recommendations.

Table 33

ANOVA Comparing Responses of District Size  
and Reporting Official(s)

|                                     | N=30<br>5A | N=20<br>4A | N=38<br>3A | N=18<br>2A | N=8<br>1A | F Ratio | Significance | Level of Sig. |
|-------------------------------------|------------|------------|------------|------------|-----------|---------|--------------|---------------|
| principal or<br>assistant principal | 4.50       | 4.50       | 4.45       | 4.39       | 4.25      | 2698    | No           | .8968         |
| counselor                           | 4.67       | 4.50       | 4.63       | 4.67       | 4.57      | .3087   | No           | .8716         |
| designated<br>teacher               | 4.33       | 4.00       | 4.00       | 4.06       | 3.13      | 3.0233  | Yes          | .0208         |
| "Care Team"                         | 4.17       | 3.80       | 3.75       | 3.67       | 3.13      | 1.6311  | No           | .1721         |
| School Nurse                        | 4.50       | 4.30       | 3.89       | 3.82       | 3.89      | 2.9737  | Yes          | .0225         |

## Chapter 5

### SUMMARY, FINDINGS AND CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this chapter was to review the study, to summarize the findings, to draw conclusions from the findings, and to make recommendations for further study. This chapter consists of three sections. They are as follows: (1) Summary of the Study, (2) Summary of the Findings and Conclusions, and (3) Recommendations.

#### Summary of the Study

Suicide has become a leading cause of death for adolescents in the past thirty years. In fact, suicide among young people had increased over 300 percent in the thirty-year period ending in the early 1980s. Little research has been done in the area of youth suicide, especially research involving school personnel. Because most students spend more time with school personnel than they do with their parents, teachers and administrators need to understand the suicidal tendencies of young people and what to do when a potential suicidal victim is identified.

This study was conducted with the sponsorship of the East Texas School Study Council (ETSSC). The topic of adolescent suicide was introduced to the ETSSC Board of Directors at the 1985 summer workshop for possible consideration as the 1985-86 research project. The board unanimously adopted this topic for research.

After a thorough examination of the literature and discussions with individuals intimately involved in dealing with adolescent suicide, a questionnaire was developed and validated by a panel of experts. This questionnaire contained three sections. First, the demographic data were addressed. Second, the components of a total school program were addressed. Third, the training needed by secondary school administrators was addressed. In addition, the study examined if there were any differences on the basis of the variables of incidence of suicide or attempted suicide, level of school, and school size. The information gained from this study should be helpful in developing a model role for schools and school administrators in dealing with the adolescent suicide problem. The study was descriptive in nature and was developed around the eight research questions.

One hundred ninety-three questionnaires were mailed to secondary school principals, whose schools were members of the ETSSC, to determine the desired and existing role of the secondary school in dealing with the adolescent suicide problem. These secondary principals also determined the area(s) of training that would be most beneficial for principals. One hundred fourteen (59 percent) usable questionnaires were returned.

#### Summary of the Findings and Conclusions

Findings, related to each research question and based on the data reported in Chapter 4, are presented below:

1. Research question one asked, "Is there a district board policy provision which deals with adolescent suicide in schools?" The data showed that only 7 percent of the responding principals reported a policy provision in their districts which addresses suicide. Since adolescent suicide has increased dramatically in recent years, schools are faced with this problem much more often. Schools appear to be rather reluctant to address the sensitive issue of suicide in school board policy.

2. Research question two asked, "What components of a suicide prevention program are most desirable and to what extent are they presently being used?" After

reviewing the data on programs, it should be noted that all thirteen components were rated as important or above. Eight of these thirteen components were rated as very important. The component which involved counselors in the identification of high risk students was rated as extremely important.

Even though all of the thirteen components were rated as important or above, none were more than 50 percent operational in the schools of the respondents. This apparent reluctance to implement desirable programs may relate to the absence of a district policy on suicide. Inservice training for professional personnel, especially for counselors, were the top rated components.

The data showed that, overall, components of a suicide prevention program are important to the secondary school principals in the ETSSC. They see suicide programs as a school-wide effort involving all professional school personnel.

3. Research question three asked, "What methods are most desirable and are presently being used in the school to identify high risk students?" The data showed that all of the identification procedures were rated as important or above. The most desirable methods of identifying high risk students were those which involve professional personnel. This is evident because the top three ranked procedures all included professional personnel in the identification process. Further indication of perceived importance is that 65 percent or more of the principals indicated these as operational in their school.

It is evident that principals think all professional personnel should be involved in the identification process, especially the counselor. Principals seem somewhat reluctant to involve students and non-professional staff in identifying potentially suicidal students. Perhaps this is due to the lack of supportive policy provisions.

4. Research question four asked, "What importance is placed on informing certain school official(s) in secondary school after high risk students have been identified?" The data show that reporting a potentially suicidal student to the proper official was considered very important to extremely important to respondents. Counselors were seen as the school officials who will be most knowledgeable and helpful after a potentially suicidal student is identified. Over 66 percent of the respondents rated informing counselors as extremely important if a student is identified as high risk.

5. Research question five asked, "What follow-up actions should be taken by the principal, or other designated person, after receiving a report of a potentially suicidal student?" The data showed that 67 percent of the principals thought it was extremely important to notify the parent after receiving a report of a potentially suicidal student. Of the responding principals, 58 percent thought it was extremely important to counsel privately with the student. All but one of the follow-up actions of potentially suicidal students was rated as very important or extremely important.

The responses in this category indicate that principals are aware of the importance of follow-up actions. Principals do not think the issue of a possible suicide should be taken lightly as indicated by the importance placed upon notification of parents and counseling with the student privately.

6. Research question six asked, "What linkages with community resources that can help in dealing with adolescent suicide are accessible to secondary schools?" The data showed that the most accessible linkages were (1) local minister, (2) Child Welfare Department, (3) local doctor, (4) local police, and (5) local mental health professional. Over sixty percent had the preceding linkages available to their schools. The linkages least likely to be accessible were (1) grief counselor, (2) a university counseling department, (3) YWCA, (4) YMCA, and (5) Alateen. Of these last five, only 20 percent of those questioned had access to them.

Principals appear to be aware of the availability of the linkages. The extent these were available varied greatly. This was probably due to the size of the district. The

data related to the training needs (research question eight) show that principals would like more training in information about agencies which deal with adolescent suicide.

7. Research question seven asked, "What importance is placed on certain actions which could be taken in secondary schools after a student suicide occurs?" Over 80 percent of the principals surveyed rated individual counseling of students by a qualified counselor as very important or extremely important. Providing follow-up counseling for close friends, teachers and groups of students was also considered very important or above.

Principals feel counseling is important for the survivors of a suicide. This counseling should include both students and teachers. Evidence that principals think the area of follow-up actions after a suicide is important is reflected in the ranking of actions. Of the eleven follow-up actions listed, eight were ranked as very important or above.

The action considered least important after a suicide was to provide for a general assembly to address concerns of students and to dismiss any rumors surrounding the suicide. The reason that providing for a general assembly to address concerns of students was rated the lowest may be due to a lack of school policy which would allow for it.

8. Research question eight asked, "What topics need to be addressed in a suicide training program that would be appropriate for secondary school principals?" The most identified topic was in the area of warning signs of suicide with 89 percent responding that training was needed. That was followed by the topic that would help principals develop school procedures that would address suicide. The third most chosen topic dealt with the referral procedures.

Principals are interested in being better informed and equipped to deal with the adolescent suicide problem. Every area except the area that addressed grief counseling procedures was chosen by over half of those surveyed as needed training. Principals see a need for personal involvement as reflected by the top importance ranking given identification of warning signs of suicide. Principals also saw the need for development of procedures. Principals apparently see their role as a proactive one instead of a reactive one.

This study also addressed the above questions by the following variables: incidence of suicide or attempted suicide, level of school, and size of school. Overall, variables had little effect on the responses of secondary school principals.

The variable of incidence of suicide or attempted suicide was broken into three sub-variables: (1) whether there had been a suicide in the district or not, (2) whether there had been a suicide in the school or not, and (3) whether there had been a serious attempt in the school or not.

The variable of whether there had been a suicide or not in the district had no significant effect on the views of principals regarding a suicide program. Nor were there statistically significant differences between principals who had a suicide in their school and those who did not.

In comparing schools which had a serious suicide attempt and those who had not, the area of programs showed a statistically significant difference. Principals who had a serious attempt thought that it was more important to introduce student curriculum addressing suicide and stress management. The distribution of materials on the signs and symptoms of suicide was seen as more important by those principals who had a serious attempt. Also, principals who had a serious attempt thought it was more important to have in-school referral processes for identified high risk students. While the data show a significance in the section on programs, it should be noted that only five of the thirteen areas were significant. The only areas where significance was shown were probably due to school size.

Dealing with the variable of level of school, the only significant difference in the

two principal groups was in the area of reporting to proper school officials. The middle/junior high principal thought it was more important to inform the school nurse and a designated teacher. These two school officials were rated lower in importance for reporting potential suicides than the other officials who might need to be informed.

The variable of school size seemed to have some relationship to responses from secondary principals. However, it was significant only in the area of reporting. The large schools thought it was more important to inform the school nurse and a designated teacher of a potential suicide than did the smaller schools. This may be because larger schools usually have more resources and personnel than do the smaller schools. Again, these two officials ranked lower in importance for reporting purposes than the other officials who might need to be informed.

Overall, it should be noted that principals see the area of suicide awareness and training as a very important issue. Principals see a need to be trained in areas which would help them more effectively deal with this issue. Principals see the counselor as a key person in the school to help deal with suicidal students. Furthermore, principals want to be personally involved in an adolescent suicide program.

### **Recommendations**

The following are recommendations for further study.

1. A study should be made to gather information from principals in states where laws require suicide awareness to be taught to students, teachers, and administrators.
2. A study should be done to compare what experts in the field of suicidology feel is important as compared to secondary school principals.
3. A study should be done to determine which, if any, actions, processes, or regulations in schools which regulate student actions might add undue stress to students.
4. A study should be done to determine the best ways to help students new to a school or district feel comfortable in their new school environment.

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